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## ORIGINAL COMMUNICATIONS.

### THE MANAGEMENT OF ABNORMAL OBSTETRICAL PRESENTATIONS.

Read before the Philadelphia County Medical Society,  
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BY WILLIAM T. TAYLOR, M.D.

WRITERS on midwifery differ as to what constitute *abnormal* presentations, some considering *all vertex* presentations as *normal*, others only those which terminate favorably, saying that if the relative proportions between the child's head and the pelvic cavity are correct, they will require no manual or instrumental assistance to conduct them safely to the end; and, as the majority of children are born head-foremost, this is certainly the most natural presentation, for then the head descends regularly into the pelvis and terminates by the uterine efforts within twenty-four hours, with perfect safety to the mother and child. But others say that if the labor is prolonged in the first or second stage, so as to exhaust the mother or risk the life of the babe, then they should be considered *abnormal*; and such is the case with many *occipito-posterior* presentations, for the occiput is compelled to traverse the whole extent of the anterior face of the sacrum, coccyx, and perineum, from seven to eight inches, before it can emerge from the vulva, instead of from two to two and a half inches, before it comes under the arch of the pubes, as in the *occipito anterior* position.

Our worthy ex-President, Dr. Albert H. Smith, says, "These are the vastly most numerous cases of delayed dilatation, requiring careful management, and most satisfactory in their results if fully understood."

As the *occipito-posterior* presentations are classed among the malpositions of the child, and often cause tedious and difficult labor, and a prolonged first stage is a bad preparation for any accidental complication of a second; although no evil may result from delay, yet we are bound to remove the cause, if we can safely do so, and save the mother unnecessary pain, which we can often do by changing the presentation with the hand.

This change was advocated by Baudelocque, Dewees, Hodge, Meigs, and other obstetricians to expedite slow and tedious labors, and Dr. Dewees said that "a physician was incompetent to practise midwifery in its best manner who could not detect and change this malposition of the head, and thus abridge by several hours the misery and pain of his patient."

It is important that these presentations should be diagnosed in the early stage of labor; and this can be done, even before the os is dilated or the membranes ruptured, by noticing a peculiarity in the shape and position of the os uteri, which was described by an English accoucheur\* many years since: "it consists in a depression of the posterior lip of the os uteri and an elevation of the anterior lip, dependent on the position of the child's head. In ordinary labor the child's head is, at the commencement of the labor, flexed upon its body; but during its progress the head becomes still more flexed by the chin approaching still nearer to the sternum. The result of this is that the posterior half of the child's head is much lower than the anterior. Consequently, in the occipito-anterior presentations, the occiput being in front presses upon the anterior lip of the os uteri, and depresses it much below the level of the posterior lip. But in occipito-posterior presentations the reverse takes place: the occiput, being behind, depresses the posterior below the anterior lip. At the same time the posterior lip, and even the entire os, are unusually low in the pelvis."

The plan which I have adopted, and advocated for several years, in these occipito-posterior presentations (I will quote from a former paper which I read before this Society in 1877), is gradually to introduce my fingers, until I can insinuate my whole hand into the womb, when the os is sufficiently dilated, and, having grasped the head, to turn it from a fourth to a second, or from a fifth to a first position, —i.e., from the sacro-iliac junction to the right or left acetabulum, which can generally be easily performed before it enters the pelvic cavity. This turn occupies but a small arc of a circle, and, if the head is born and the body has not changed its position, the slight twist of the neck will

\* J. G. Swayne, M.D., of Bristol, England. Provincial Medical and Surgical Journal, February 18, 1852.

produce no injury, for a return of the head to the original position will occur before the body is born. It is sometimes necessary to keep the head in the altered position with the hand, until the forceps can be applied. The head, however, will not revert to its former position if the body also is turned, which can be accomplished without much difficulty by the hand. For if the hand is used carefully and intelligently, it will "work wonders" in all obstetrical operations, and with a little experience you will soon acquire the *tactus eruditus*, and will not grope blindly when obliged to use the forceps or other obstetrical instruments.

Dr. Dewees, who advocated this change of a "forehead front" into an "occiput front," said "that even in a pelvis contracted 'antero-posteriorly' we may assist the woman to deliver herself by applying two or three fingers to the side of the head so as to carry the vertex towards the acetabulum." In fact, he recommended this change where it was practicable, and the late Professors Hodge and Meigs seconded his views.

When, however, the head is jammed down in the pelvis, we must place the woman in the "knee and elbow" position of Dr. Thomas, and endeavor to push it above the narrow part, which can thus be accomplished most readily, for, the fundus being lower than the os, the child gravitates somewhat towards it, and the expulsive pains are less, and sometimes cease entirely.

If, however, we cannot alter the presentation, and the labor is protracted too long, no advance being made by the head, or the mother is exhausted, we must deliver with the forceps, being careful to remove them when the head has passed through the inferior strait, so as to protect the perineum, which is in greater danger of being torn than when the occiput is front.

*Face presentations* occur, according to Dr. Thomas, once in two hundred and fifty labors, and are caused by some obliquity of the uterus, or a pelvic contraction, which presses the child's head backwards, and the chin departs from the breast.

If the chin is at the pubes and above the brim, it can be changed to an occiput posterior by pushing it towards the breast; then it can be turned anteriorly (as before

described), when the labor will proceed naturally. But if the chin is below the pubic arch, a long time will be required before the occiput can move along the sacral curve, and the pressure may cause the death of the child, unless delivery is effected by the forceps.

When the chin is turned towards the sacrum, if we can push it up early, so that the occiput comes down anteriorly, we will have no trouble; but if the chin is below the promontory of the sacrum, and the forehead front, it should be left to nature as long as possible, assisting, however, to turn with the hand or vectis, for as the labor proceeds the head will generally turn in the pelvic cavity, with the face forward, and at the outlet the upper lip will be fixed against the symphysis, whilst the occiput will roll over the perineum; then at last the mouth and chin will emerge from under the symphysis.

If, however, no advance is made by the expulsive pains, the forceps must be used to turn the chin forward, as thus described by Smellie: "After applying the forceps along the ears, push the head as high up in the pelvis as is possible, after which the chin is to be turned from the os sacrum to either os ischium, and afterward brought down to the inferior part of the last-mentioned bone. This done, the operator must pull the forceps with one hand, while two fingers of the other are fixed on the lower part of the chin or under jaw to keep the face in the middle, and prevent the chin from being detained at the os ischium as it comes along, and in this manner move the chin round with the forceps and the above fingers till brought under the pubes, which done, the head will easily be extracted."

If the child is dead, craniotomy may be required.

Dr. Barnes, of London, says that in cases of due relation of pelvis and child, birth with the chin posteriorly is almost impossible; for in proportion as the face descends, there is a rapidly widening base of a wedge formed by the occiput bent back upon the child's trunk, which cannot pass the pelvis; but that turning and delivering by the feet is the best course, yet if the head is low it may be difficult to accomplish.

That it is difficult is unquestionable; but if the hand can be introduced alongside of the head to reach the feet, the

head itself might be turned to a more favorable position.

In these cases Dr. Isaac E. Taylor, of New York, suggests the division of the perineum laterally, on whichever side the chin presents, before craniotomy is performed; but I doubt its benefit,—for the chin is not generally arrested by the perineum; and if the child is dead, why inflict unnecessary pain on the mother?

The next abnormal presentation to which I will refer is the *shoulder*, in which the *back* of the child will be either towards the abdomen or the back of the mother. In dorso-anterior positions the right shoulder will be felt if the head is in the left iliac region, and the left shoulder will present if the head is in the right iliac. But in dorso-posterior positions the left shoulder will be lower in the pelvis, if the child's head is in the left iliac fossa; and the right shoulder will present if the head is in the right iliac region.

We are all aware of the fact that, unless the child is small, it is impossible for the shoulder and head to pass together through the pelvis, and therefore delivery can only be effected by the head or breech singly.

For many years the latter was considered the only proper mode, especially before the forceps were known in midwifery; as the accoucheur could then assist by taking hold of the feet and legs. Some even now prefer podalic to cephalic version; but by bringing down the head we can deliver with the forceps if necessary.

It is an established fact that in shoulder presentations nature has sometimes effected delivery by spontaneous version, terminating it by a breech or foot presentation; but it generally requires so much time that the child perishes during the act. Now, if we can expedite the labor, and give the child a chance for its life, it is our duty to do so; and that we can do by *cephalic* version.

The plan which is considered the best, and which is generally practised, was first suggested by Dr. Wright, of Cincinnati, about 1850.

The patient should be placed so that her hips will be higher than her shoulders, inclining towards the side upon which the head of the child lies, so that the breech will gravitate towards the fundus of the uterus on the same side, and thus assist to draw the child away from the brim of the pelvis.

The right or left hand is to be used in the vagina or uterus as is most convenient, according to the position of the head. When the child's head is in the left iliac region, we should use the right hand, and with the fingers push the shoulder towards the right side of the pelvis, whilst with the left hand we press down the fundus in the opposite direction. This will generally cause the shoulder to move to the right, and the head will occupy *its* place in the pelvic cavity.

When, however, the foetal head lies on the right side of the ilium, the fingers of the left hand should be used against the shoulder, whilst the right hand is used on the outside of the abdomen, placing the patient in a position similar to that described, but on the right side.

By this mode version is generally effected quite easily. If, however, we cannot cause rotation, we must bring down the feet and deliver by the breech.

The rule to be adopted in *breech* presentations is "masterly inactivity," to sit patiently beside the patient and encourage her during the first stage of labor, allowing the os to dilate until the expulsive pains begin, when, by pressing down the fundus of the uterus towards the os by a kind of *vis-a-tergo* force, we can assist the smaller end of the foetal wedge to dilate the os gradually, and also keep the chin of the child firmly fixed on its breast. As the body advances and the umbilicus appears, we should pull down the cord slightly, to remove it from pressure; if its pulsations are strong, wait for nature to act; but if they are very weak, we must assist the expulsive pains by drawing down the body. When the chest is born, if the arms are near the body they can be brought down quite easily; but if they are alongside of the child's head we must pass one or two fingers over the shoulder to the elbow, gradually drawing the arm over the face and chest until it is delivered, beginning with the one next to the perineum. As the head passes through the inferior strait, if the pulsations of the umbilicus are yet strong we can wait for the expulsive pains; but if the cord beats feebly we must hasten the labor by placing two fingers on the upper lip or one on each side of the nose, and press firmly down, so as to keep the chin towards the breast, whilst we pull the body towards the symphysis pubis; if it does not advance speedily we must use the

forceps, for delay at this time will often sacrifice the child.

The most favorable presentation is when the back of the child is anterior, so that the occiput shall come down under the pubic arch; although when it is posterior the head will often turn in the pelvic cavity, and be born with the occiput front.

A presentation of *the feet* should be managed like that of the breech, the rule being to let them alone until pressure on the funis obliges us to act as before described. If one foot is in the vagina, and no advance is made, we should search for the other, and, having brought it down alongside of its fellow, wait awhile for pains, applying, however, a downward pressure on the fundus to stimulate uterine action.

*Prolapse of the funis*, when it occurred, was frequently the cause of death to the child, until the postural treatment of Dr. Thomas was adopted as described by him in 1858. It consists in placing the patient on her elbows and knees, with the face and chest resting on the bed, so that the fundus of the uterus shall be lower than the os; then, by introducing the hand into the vagina, we can with the fingers easily press the descending loop into the os, and above the side of the descending head, or other presenting part, into the dependent uterine cavity.

Presentations of the *head* and *funis* or *arm* and *funis* can be rectified by placing the patient in the knee and elbow position, and pushing up the head or arm from the Grin, when the funis will easily slip back, or can be pushed into the uterus, so that the head can descend alone.

If the *hand* and *foot* are presenting, we must bring down the foot and deliver as in footling presentations.

*Placenta prævia* is generally recognized during the latter part of utero-gestation by the patient having a hemorrhage after some exertion, or even when quiet: this may occur periodically, at the menstrual epochs, and may cause premature labor.

On examination per vaginam, if the os is beginning to dilate, a soft spongy substance will be felt within, and we recognize the placenta. With each pain, as the os dilates, there is a flow of blood, and if this continues it will exhaust the mother and destroy the child: so that we must arrest it if possible. We should pack the vagina firmly, up to the os, with strips of soft

muslin, linen or silk, tow or sponge, to prevent any oozing, and wait beside the patient for the pains to dilate the os, and to be ready for any emergency. In from half an hour to an hour, according to the pains and condition of the patient, we should remove the tampon, and if the os is sufficiently dilated to introduce the finger, it should be passed between the placenta and the uterine wall, and swept around as far up as it can reach, so as to separate the attachment. This will temporarily check the bleeding; but when it returns, tampon again and wait for further dilatation. When the plug is again removed, sweep the finger around again, within the os, as far up as it can reach, and if the edge of the placenta is felt and we can reach the "bag of waters," it should be ruptured, for then labor will proceed in earnest, and the expulsive pains will bring down the presenting part of the child, which should be hastened by every means in our power,—by pressing down the fundus, stimulating the uterus with ergot, and delivering as rapidly as is consistent with the safety of the mother and child.

If the presentation is a *partial placenta prævia*, and we can detach it from one side of the uterus so as to rupture the membranes and bring down the child to the os, the hemorrhage will cease, and the delivery need not be hastened so much, for the circulation between the mother and babe may be kept up, so that its vitality will be preserved somewhat longer.

In all obstetric operations, when the patient was very nervous, uncontrollable, or required an anæsthetic, I have given ether to inhale alone, or with the addition of a small quantity of chloroform when the ether was too slow in producing its effect. I have also used with much satisfaction the mixture of the Medico-Chirurgical Society of London, containing one part of alcohol, two of chloroform, and three of sulphuric ether, which causes anæsthesia in a shorter time and requires smaller doses for inhalation than ether alone.

Now, in conclusion, permit me to say that although I have not detailed minutely all the varieties of abnormal presentation, yet I have given some of the modes by which such cases are managed, knowing full well that a free discussion may bring out the experience of others, who will give clearer



views on this subject than I have been able to furnish.

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## THE TREATMENT OF GLEET BY ELECTRICITY.

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THE use of electricity in any form would not readily suggest itself to the general practitioner in the treatment of urethritis, acute or chronic, simple or specific. From accessible reports on the management of gleet, I am inclined to believe that gentlemen who devote special attention to diseases of the genito-urinary organs have not availed themselves of this agent or experimented with it. In order to verify my opinion on this matter, I have, during the last two years, by personal inquiry, learned that not a single case has ever been subjected to electrical treatment by any one of one hundred physicians whom I have interviewed on this subject. Further, in looking over nineteen works on medical electricity in my library, I find that only once is mention made of the use of the current in urethral discharges,\* two cases of gonorrhœa being referred to, and a passing allusion only with reference to gleet.

Curiously, the value of galvanism in overcoming strictures otherwise impassable without cutting or forcible divulsion is recognized by several of these authors, and in a large number of these cases (in fact, the majority of them) the origin of the stenosis thus overcome by electricity was due to repeated gonorrhœas and associated with gleet. It is true, however, in these cases, that few sittings were made in overcoming the strictures, and therefore not much effect was noticeable by the surgeon on the urethral discharge. I must confess to a want of enthusiasm in research (if I may so term it) myself, because during many years past it has been my habit to notice the effect of electrical treatment on the general health, and its reflex action when employed for a definite purpose on other and distant parts of the body. For instance, in all cases of intercostal neuralgia, and in applications near the mammary region in women, I have kept note of any reflex action on the uterus or ovaries, such

as, for example, an increase or decrease in the menstrual flow, and the converse, when treating dysmenorrhœa,—what effect, if any, did treatment have on the lacteal glands? Repeatedly I have proved to the satisfaction of myself and the patient that turgescence of the mammæ followed faradization of the womb or ovaries, and, inversely, that the *molimen menstruale* was both hastened and increased when treating pleurodynia or some other disorder of the antero-thorax. I have treated now a large number of cases of genital defect, particularly spermatorrhœa, impotence, and irritable prostate, by electricity, and yet I never thought of experimenting on the gonorrhœas of these patients or their friends, although they were frequently available, until the subject was thrust on me by pure accident. One of my professional friends, who has, unfortunately, too little confidence in himself in the way of minor surgery, especially of the genito-urinary organs, has many a time sent me patients troubled with stricture, either spasmodic or an old case irritated by some cause. In all these instances I have wasted no time, and troubled the person as little as possible by poking a multitude of bougies or catheters into him, but if, after trying gently a few sizes, I do not get into the bladder, I invariably insert an insulated urethral electrode, and pass a current of five or ten millivebers† through the constricting obstacle, with the effect of softening it down in a short time, and gaining my object with the minimum trouble to both of us.

In one case, a stranger to me, who was a martyr to a gleet which worried the life almost out of him and his washerwoman, who (good and unusually innocent soul) could neither efface the lemon-colored stains from his linen nor account for their mysterious presence, the patient told me, after submitting to some half a dozen sittings, that his gleet was better than it had been for a year past, and inquired whether the electricity had anything to do with this unlooked-for and gratifying result. It did not strike me at the moment that it might, and I expressed my belief that the resolution of the stricture was the cause of his improved condition. After some time, however, he returned, stating that from indiscretion the gleet had been to some extent re-established, and he proposed elec-

\* Medical and Surgical Electricity. Beard and Rockwell, 1st ed., p. 660. New York, Wm. Wood & Co., 1871.

† Fifteen to twenty Daniell's; but frequently five to eight cells will do.

trical treatment rather than again undergo the tedious and inefficient course which had taken place before I got him under my care. As no harm could result beyond a little delay, I agreed to his proposition, and, to the gratification of both him and myself (not to mention the washerwoman, who was once more despairing), he did get rid of his gleet; and from that time forward I tried electricity in every case I could get hold of. I have treated during five years past nearly two hundred different patients, and in almost every one of them more or less experiment has been made as to the prospective or actual value of galvanism and faradism in such cases. The result of this investigation has been exceedingly gratifying to me, and the percentage of success, due undoubtedly to the particular treatment employed, has been such as to warrant me in saying that in no other method has the patient been more promptly or more radically cured. This is saying a good deal; but I mean it fully. Gleet is a tough and unsatisfactory customer to handle, and, although plenty of cures exist on paper, and lots of confiding students listen to the words of wisdom as they drop from the mouths of their professors in the winter course and their auxiliary teachers in the summer months, they find, when in actual practice, that somehow or other their patients do not improve under these prescriptions, and that gleet once established generally sticks, and the most provoking part of the trouble is that the heartier is the general stamina of their patient the more obdurate is his infirmity to any and all measures.

For some years past the belief that gleet nearly always depends on stricture has been asserted by prominent authorities, and this more particularly by Otis, of New York. A number of ingenious instruments for the gradual or rapid dilatation or divulsion of stricture have been produced, and without doubt they accomplish their purpose, but at the cost of considerable suffering, and confinement of the patient to his bed for some days, and restriction from following his business for at least a week or more. Now, the same result can be reached, with less manual trouble to the physician and much less physical trouble to the patient, by electrolysis. The proceeding is neither difficult nor painful; anæsthesia is never requisite, and within my own experience, or so far as I can learn from others who

have employed this method of operating, no ulterior bad result has ever followed it. There may be strictures impassable by insulated bougies, yet none of them have been encountered by myself. With this much concerning stricture, which is not so much a digression as might be thought, the main point is reached.

The treatment of gleet by electricity is based upon a procedure essentially like that of stricture. The requisites are a galvanic battery of fifteen to twenty cells of any constant form, such as the zinc-carbon, of Grenet or Léclanche type, the Daniell, or the Smee, a good faradic coil, several urethral bougies well insulated to the tip, a rectal electrode, and a sponge-holder. A *water* rheostat is a valuable addition, as by it we can readily intercalate any needed resistance without shock, and nicely graduate the current to its proper strength. The patient is placed in a horizontal position on a lounge or operating-chair, the genital organs, abdomen, and thighs exposed, and the galvanic battery placed to the left of the operator. A moderate-sized bougie is slightly oiled, and passed on into the bladder if the canal is pervious, or to the stricture if one exists. To the urethral electrode is attached the negative, and to the sponge-holder the positive pole of the battery. The sponge should be well wetted with salt water, and applied over the bladder or on either thigh, it matters little which. The current is now turned on slowly until plainly but painlessly felt by the patient. If no stricture exists, the bougie is slowly withdrawn until it approaches the glans, when it is again pushed towards the bladder. Under this manoeuvre, here and there some little uneasiness, or even pain, is elicited, and at such points the inflamed urethra is probably bare of epithelium, and it is there that the pus or muco-purulent discharge is manufactured. The limits of this painful area being determined, the electrical application is confined to that part alone, and the intensity is graduated to an easily bearable point. From fifteen to thirty minutes is an ordinary séance, and this should be repeated daily, or, better still, if circumstances admit, twice daily. Should stricture prevent access to the bladder at once, gentle but firm and continuous pressure is made by the bougie, with as strong a current flowing as the patient can stand, and in a few minutes usually the stricture will yield,

even though it be gristly and tortuous. In such cases it will of course be necessary to employ small bougies, on the same principle followed in ordinary management; but, as before stated, I have so far not failed to pass any stricture ultimately, although I did not succeed in several instances at the first sitting, and sometimes not until the third.

Notwithstanding the difficulty of penetrating the constricting band, the gleet discharge has, as a rule, been notably decreased by the operation in the cases just referred to, and in several tight strictures I have purposely made the electrical applications to the proximal end of the band for a considerable length of time without pushing the electrode beyond it. Despite the fact that the stenosis still existed, the gleet became less in such cases, proving to my mind the value of constant currents on inflamed surfaces, particularly of mucous character. I also believe that most, if not all, of the discharge in stricture cases originates just in front of the constriction, because I have often had the secretion to cease for a considerable time by treating the gleet without pushing the electrode onward to the bladder. In cases where the gleet is deeply seated, or where we encounter enlarged prostate, the rectal electrode is preferable for the anode to a sponge handle as before described. The instrument should be insulated around the shoulder or part which is grasped by the sphincter ani, as in many persons this part of the bowel is especially sensitive. Before introduction, the electrode should be oiled, and after its insertion the distal end should be directed towards the anterior face of the rectum, for currents being more or less diffused laterally are not only unpleasant if they traverse the sacral plexus, but the extra strength required, unless the two electrodes are nearly approximated, renders the urethral intensity too great for comfort. This may appear a small point; but little niceties tell in electrical applications, and all currents should be not only easily bearable, but without any discomfort, and this rule holds good in all practice, with a very few exceptions. To further this, the rectal electrode should be not the common ball, an inch or more in diameter, as usually found, but a conical rod four inches long, from which the flow escapes over a large surface. The urethra is not much more sensitive than the rectum,

but the reason why currents easily borne by the bowel are painful in the former is because they are concentrated at a small point, and in the operation under consideration a more or less caustic action is induced by strong currents at the cathode, the alkalies being set free at that pole. The moist condition of the urethra favors this action, for, other things being equal, tissues which contain the most water yield more readily to electrolysis than the dryer portions of the body. In conjoined rectal and urethral electrization the sitting need not be so long as in the method first described, because the effect desired is more directly attained. From five to ten minutes will suffice.

After getting rid of all discharge, it is a good plan to employ faradism for a few times, as it seems to tone up the relaxed mucous membrane. I suppose any mild astringent injection would answer the purpose equally well, but, having in all cases treated solely by galvanism used the induction coil with perfect satisfaction, I have adopted a routine plan thus far. In many old cases, more or less lumbago and ill-determined pain in the region of either kidney is encountered, and nothing drives this away so quickly and permanently as faradism. The usual plan is to apply the positive to the lumbar spine, and make labile application to the whole abdomen, back, and sides. Pretty strong currents are used, but the pressure should be light, and undue contraction of the muscles, especially the rectus abdominis, should be avoided.

During the entire treatment no medicine is administered, except, of course, to regulate the bowel if constipation presents; and even then the induced current, with massage of the abdomen, is better than drugs in those patients who will carefully comply with the instructions necessary for systematic manipulation of the abdominal muscles. Some people are too lazy to use a rapidly-performed sponge-bath of the abdomen and follow it by a few minutes' kneading. They prefer Seidlitz mixture or a mineral water, although permanent good results are attained by the mechanical treatment, and temporary relief only through the ordinary drugging. Diuretics are not necessary in any case, and all injections must be stopped during the electrical treatment. The diet must be carefully regulated, especially with reference to alcoholic

stimulants, which are to be rigidly tabooed. The belief that gin is a valuable remedy in bladder and kidney disorders leads many patients to take it on the sly, unless the physician is alert, and I am satisfied that a multitude of gleet discharges are kept alive because the doctor does not rigidly control his cases, and not through any fault in the medicines administered.

Relapses in gonorrhœa and gleet are quite common, and I have found this to occur with patients treated by electricity in about the same proportion as obtains with other methods. In such cases inquiry generally elicits a history of excesses in both diet and sexual intercourse. Men who have been kept total abstainers for some weeks are apt to overdo such matters at first, which is probably natural. Under a recurrent discharge, the treatment must be renewed as in a new case, and a few applications only will usually be needed to quiet the storm, and thereafter sensible men will observe moderation.

I am experimenting on a few female cases which, although they may not be strictly classed as gleet, have been at least kept up, if not originated, by relations with men thus affected. To my mind a goodly number of inveterate so-called leucorrhœas are of this nature, and they are very difficult to cure under any plan. The large surface and the hidden folds of the vaginal lining afford lurking-places for enough irritating mucus or muco-pus to prevent total relief, except with unusually careful patients, who are willing to take the trouble of thorough cleaning at least half a dozen times daily. The vagina is with difficulty reached in its whole extent by electricity, and the plan most satisfactory to me as yet is to distend it fully with salt water, which is retained by a shield or plug surrounding an electrode an inch in diameter and six inches long in its uninsulated portion. Double quantity of current is necessary to overcome the resistance of the water thus employed.

246 NORTH TWENTIETH STREET.

THE use of the bicycle and tricycle has become quite the rage among prominent doctors in England, and the wheel is gaining some advocates here. Dr. A. W. Blythe gives a very interesting lecture in the *Boston Medical and Surgical Journal* on "Cycling," which deserves attention from those who practise in a level country.

## VIRULENCE OF NORMAL HUMAN SALIVA.

BY GEORGE M. STERNBERG,

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I should be sorry to dose the readers of the *Medical Times* with saliva *ad nauseam*; but, having additional experimental data to record, I have thought it best to publish at once, while the subject is still fresh in the minds of the readers of this journal from a perusal of Dr. Claxton's paper\* and my own.†

Moreover, the facts relating to the infectious disease of rabbits, resulting from the introduction into their bodies of a parasitic micro-organism found in normal human saliva, have so important a bearing upon the general question of the etiology of infectious diseases that I think it very desirable that their force and import should be fully appreciated by the profession.

Before proceeding, I beg leave to call attention to the innovation in my previous paper with reference to the name of this infectious disease. I have always spoken of it as a "fatal form of *septicæmia*," and so wrote the word wherever it occurs in the paper referred to. It has been changed, however, by the proof-reader to *septicæmia*, which is perhaps a better word, and which I am quite ready to accept upon the authority of the editor of this journal. But it seems to me that this word would be more properly used as applied to a non-infectious septic toxæmia, resulting from the absorption of the chemical products of putrefaction, leaving the word *septicæmia* as the distinguishing appellation of those infectious diseases which result from the multiplication of parasitic micro-organisms within the body of infected animals,—e.g., anthrax septicæmia of the mouse,‡ fowl-cholera,§ etc.

I leave this question with the editor, and shall be pleased to be guided in my future use of these terms by his authoritative decision.

In my previous paper I related a series of experiments commenced July 6, to which I must refer the reader as properly introducing the following:

The culture-fluid (No. 6) used in *Experiment No. 3* (July 26) was laid aside in an hermetically-sealed culture-flask until September 12, when a minute drop was used

\* Times, June 17.

‡ Koch.

† *Ibid.*, September 9.

§ Pasteur.



to inoculate sterilized *bouillon* in culture-tube No. 7. This, placed in a culture-oven at 100° Fahr. for twenty-four hours, became clouded, and upon microscopical examination proved to be pervaded with the identical micrococcus heretofore described and photographed.\* A drop of culture No. 7 was used to inoculate culture No. 8, and the next day, this being also pervaded by the micrococcus, was used in the following experiment:

*Experiment No. 4.*—September 14: Injected ten minims of culture No. 8 into a full-grown rabbit. *Result:* This animal died at 9 A.M., September 15, and a microscopical examination made at once demonstrated the presence of the micrococcus in great numbers in the blood and in effused serum in the subcutaneous connective tissue. The usual diffuse cellulitis, extending from the point of inoculation, was present; spleen small, and contained no pigment.

*Remarks.*—This experiment shows that the micrococcus retained its vitality and its full virulence at the end of six weeks, and, very conclusively, that the virulence of the culture-fluid is due to the presence in it of the micrococcus, and not to a hypothetical chemical virus found in the first instance in the saliva and subsequently in the blood of a rabbit inoculated with this fluid. For the benefit of those who have not calculated the degree of dilution which such a hypothetical chemical virus would undergo in such a series of culture-experiments, I submit the following simple calculation:

My culture-tubes contain about a fluid-drachm of sterilized *bouillon*. The amount of blood introduced into culture No. 1, as seed, was considerably less than a minim, but for convenience I will suppose that one minim is used each time to start a new culture,—that is, the original material is diluted 60 times in the first culture, 3600 times in the second, 216,000 times in the third, and in the eighth culture it will be present in the proportion of one part in 1,679,611,600,000,000. Yet a few minims of this eighth culture possess all the virulence of the first.

Look at it from another point of view. The few minims of culture-fluid introduced beneath the skin of a rabbit contain a mi-

crococcus presenting definite morphological characters. The blood of the animal which falls a victim to experimental inoculation with this fluid is filled within forty-eight hours with the same micro-organism in numbers far exceeding the normal histological elements,—red and white corpuscles; yet some very conservative physicians still claim that the invading parasite is without import, a mere epi-phenomenon, while the infinitesimal portion of a hypothetical chemical virus is credited with this malignant potency. Truly, such a belief requires a faith equal to that of a conscientious homœopath. By the way, what will become of homœopathy if the germ theory becomes firmly established, and all infectious diseases are shown to be due to parasitic micro-organisms? If the main end of therapeutics is to kill germs, the doctrine of *similia similibus* can scarcely control the medical practice of the future.

To convince those who still question the etiological rôle of the micrococcus in the infectious disease of rabbits at present under consideration, it would hardly be worth while to carry our culture experiments further, as has been done by Pasteur and other pioneers in this field of investigation,—e.g., in anthrax and in fowl-cholera. I therefore turn to another line of proof.

I have fixed very definitely the thermal death-point of this septic micrococcus. *It is killed by exposure for ten minutes to a temperature of 140° Fahr.* It survives exposure to 130° for the same time. This is the result of a considerable number of experiments, and is established by the simple method of exposing a culture-fluid containing the micrococcus, and enclosed in a hermetically-sealed tube, to a given temperature for the time adopted as a standard,—ten minutes,—and then using the fluid to inoculate sterilized *bouillon* in another tube. This, being placed in a culture-oven for twenty-four hours, remains transparent and unchanged if the seed has been killed, but is clouded and pervaded by the micrococcus if its vitality was not destroyed.

In my first series of experiments† I found that boiling destroys the virulence of blood from a septicæmic rabbit. Having now fixed with precision the thermal death-point of the micrococcus, the next step was evidently to see whether this temperature also destroys the virulence of the fluid containing it.

\* *Vide Studies from Biological Laboratory, Johns Hopkins University, vol. ii., No. 2, p. 194, and heliotype plate in vol. ii., No. 3, p. 410.*

† *Loc. cit.*

To test this matter, the following experiment was made with the second culture from the blood of the rabbit which died September 15, as above reported.

*Experiment No. 5.*—September 7: Injected ten minims of culture No. 2 beneath the skin of a small spotted rabbit, also ten minims of the same culture-fluid beneath the skin of a small white rabbit of the same litter. *Result:* The small spotted rabbit was found to be dying the following morning at eight o'clock. It was killed by breaking up the medulla, and the blood from the heart examined immediately. This contained the micrococcus in abundance, as did also a quantity of serum contained in the pleural cavity and effused serum in the subcutaneous connective tissue.

The small white rabbit, injected at the same time with the same culture-fluid heated to 140° for ten minutes, did not seem to experience the slightest ill effect from this injection, and to-day (September 24) remains in apparent good health; that is, *the virulence of the culture-fluid used in this experiment was destroyed by the exact temperature which I had previously determined to be fatal to the vitality of the micrococcus.*

#### PLICA POLONICA.

BY FERDINAND LESSING, M.D.

ANNA T., æt. 16, went six weeks ago to the country with a lady friend, and, rambling about in the woods, they came to a cold spring, and washed their feet in it. Next day A. felt chilly and languid, appetite impaired, together with shooting pains through her limbs. A week after, she noticed that when combing her hair she could not pull the comb through as readily as heretofore, and by about a week more her hair was a matted mass. The symptoms of pains in her limbs had increased in proportion, as also a neuralgic pain in head and eyeballs. Two weeks before her death I was called, and found the sufferer in the following condition: She cried from the excruciating pain in limbs and head, the former being in a continuous state of tremor. Extremities cold, tongue clean, pulse 65, appetite gone, insomnia complete, and menstrual function stopped. I ordered her potassium bromide and chloral, also a tonic consisting of quinia sulph., iron, nux vomica, and arsenic. Gave her also wine and milk-punch *ad libitum*. The trembling of her limbs, as also the pain in head and eyes, had somewhat improved under this treatment in the course of a few days, yet her pulse grew weaker, and on the thirteenth day from the beginning she quietly passed away.

I give only a short synopsis of this peculiar disease, which I have so far found only among the Poles, which class is largely represented here. The treatment of the plica itself is, I believe, up to this day, not a settled one. Some authorities advocate the removal at once, others caution strongly against it. As regards the cutting, these people will never allow it. They state that it will either kill or cause blindness; and in this case the family referred me to a case in the country who got blind owing to the removal. The theory that the disease is the result of filthy habit I cannot uphold. This case convinced me otherwise. The hairs exude a gelatinous matter and get actually painful to the touch. It seems that they act as an emunctory, to rid the system of a dyscrasia. Those who get well will not cut off their hair until the new growth has well advanced, for which process they claim about a year's time.

I report this case, hoping to elicit the experience and opinion of some other members of the profession, as it will certainly come under the notice of those who have practice among the Poles, Bohemians, Lithuanians, and Russians.

WINONA, MINN.

#### TRANSLATIONS.

PARTIAL (JACKSONIAN) EPILEPSY—COINCIDENCE OF HEMISPASM WITH MOTOR HEMIPLEGIA, AND ITS DIAGNOSTIC VALUE.—Dr. W. F. Raymond recently presented at the Hôtel-Dieu (*Le Progrès Médical*, No. 38), an interesting case of partial epilepsy in a young girl 24 years of age, who appeared to be in perfect health. Upon speaking, however, it was observed that her responses were distinct, though rather slow and scanning; if she tried to speak faster, she stammered slightly; but there was no paralysis of the tongue or fibrillary trembling. There was almost complete immobility of the right half of the face. There was also marked, but not absolute, loss of power in the right arm, with moderate rigidity. On raising the arm, she could only maintain it extended for a very brief period, and during this time there was decided tremor of the forearm. There was no disturbance of sensibility. The right leg was less affected than the arm, though it exhibited the same features in a less degree. The tendon and cutaneous

reflexes were preserved and scarcely exaggerated. The sphincters were not affected. No hysterical symptoms were present. The menses were regular. Syphilis was excluded.

The patient stated that she had been in excellent health, except that she had not menstruated up to the age of nineteen, when she felt weak and was obliged to give up a position as seamstress, the work being too fatiguing. She had never been nervous. Six months after this she had an apoplectic attack on rising in the morning, losing consciousness for about five hours, after which she was completely aphasic and had right hemiplegia. At the end of twelve days she began to regain a few words, and her speech thereafter gradually returned, and she also regained the use of her limbs, so that in two months she was able to walk. She also said that about one month after her attack she had sudden clonic spasmodic movements on the right side, lasting from four to five minutes. During the whole of this period she remained perfectly conscious, but powerless. Subsequently these convulsive attacks recurred without regularity, coming on after slight causes, or from no apparent cause. They were almost always preceded by an aura and a feeling of stupor, but she did not lose consciousness, and never had the epileptic cry, any disorder of intellection, or any of the usual attendants of ordinary epilepsy. After the apoplectic attack, the menses appeared and continued regularly afterwards; the spasmodic attacks had no relation whatever to the menstrual period.

Locating the lesion in the left hemisphere in the motor region of the cortex (the fronto-parietal convolutions), and stating his opinion that it had been followed by degeneration extending from the third frontal convolution along the anterior portion of the internal capsule into the medulla and the right lateral column of the cord, the lecturer proceeded to discuss the pathology of partial epilepsy, and the character of the lesion. The diagnosis, after exclusion of cerebral tumor, meningeal hemorrhage, pachymeningitis, cerebral extravasation, was finally pronounced to be that of local softening, but whether dependent upon thrombosis or embolism was not decided. The prognosis was favorable up to a certain extent, but entire recovery was not looked for. Iodide of potassium was ordered, and,

as soon as signs of irritation subsided, the induced electrical current should be used. Jackson and Müller lay down the following differential signs between symptomatic and so-called idiopathic epilepsy:

1. In partial epilepsy there is no cry; the patient is conscious at the beginning of the attack, or throughout the entire proceeding if it is limited to one-half of the body.

2. In partial epilepsy the attack, with rare exceptions, is scarcely at all made up of *clonic* movements; but contraction, ordinarily very prolonged, commences in the same muscle and in the same muscular group. "The more the spasm begins suddenly, the more it commences to extend rapidly, the more the degree which it attains will be great, and the more the duration of the access will be short; and reciprocally." [The words in the original communication of Hughlings Jackson, as found in the official report, are, "The more suddenly the spasm sets in and the more rapidly it begins to spread, the greater range does the convulsion ultimately attain, and the sooner over is the paroxysm. On the contrary, when the spasm starts deliberately and spreads slowly, it is more likely to be limited in range, say merely limited to one arm, and to be lengthy."—Tr.\*]

3. Paralytic and oculo-papillary phenomena are very common in partial epilepsy.

4. After the limited convulsive attack there remains usually a paralysis, sometimes temporary, sometimes permanent.

5. If the attack becomes general, the paralysis occurs on the side where the convulsions have been the strongest and the side where they have persisted the longest.

In these cases the local epilepsy points to a localized cerebral lesion. It was also remarked that in paralysis of cortical origin, the hemiplegia may completely resemble hemiplegia of central origin,—so completely, in fact, that the secondary descending degeneration sometimes follows, as in the present case; but secondary degeneration does not occur when the cortical lesion is situated outside of the motor zone.

**IODOFORM IN THE AFTER-TREATMENT OF OPERATIONS UPON THE MOUTH.**—Wölfler reports in the *Archiv für Klin. Chirurgie*

seventeen operations for removal of cancerous tongue. None terminated fatally: on the contrary, in many there were no signs of inflammatory reaction. In all the after-treatment or dressing was by iodoform gauze. The following is the method of preparing this material at Billroth's clinic: Six metres of gauze is rolled up and dipped in a mixture of glycerin (60 grms.) and in an alcoholic (1200 grms. of 94°) solution of colophony (100 grms.), and then pressed out, and while in a half-damp condition it is dusted with iodoform (about 50 grms.) and dried. The gauze is then cut into strips of two or three finger-breadths, which are then to be packed into the wound, though without exerting too much force. The superficial layers of this only are changed as they become soiled, and new pieces of gauze put in their place for six or eight days; after this the dressing will fall out of itself. In all this time no other cleansing of the mouth is necessary; but efficient drainage should be provided by counter-opening, or a drainage-tube be used for a few days. Pneumonia or septic symptoms were not observed in any of the cases treated in this way.

**EFFECTS OF COLD UPON TRICHINÆ.**—At the Société de Biologie of Paris, M. Paul Gibier recently presented, in the name of Prof. Bouley and himself, the results of some experiments undertaken by them in order to determine the results of cold upon the vitality of trichinæ contained in American hams. The existence and vitality of the trichinæ were first ascertained by the microscope, by chemical agents, and by physiological experiment upon birds, which, after eating the meat, were found to contain in the intestines, and to discharge in their excrements, large numbers of trichinæ. The same meat was then exposed to cold in a freezing-apparatus. The examination of the frozen meat demonstrated that all the trichinæ which they contained were dead, the means taken to ascertain this being the same that had already been employed to determine their vitality. The authors conclude that the temperature of 0° C. (32° F.) is very injurious, if not fatal, to trichinæ. After several weeks the frozen meat did not undergo any subsequent alteration: so that the cold does not destroy the effects of the salt and the smoke.

The same effects have been previously

observed by Messrs. Livon, Bouisson, and Caillol de Poncy, in experimenting with cold upon trichinæ. "It appears to have been demonstrated that science possesses in refrigeration a powerful agent for rendering trichinosed meat wholesome, and that it affords to public hygiene a method which should be made serviceable in the treatment of trichinosed meat."—*Le Progrès Médical*, No. 27.

**POISONOUS MUSHROOMS.**—The researches of Ponfick (*Virchow's Archiv*, June, 1882) prove that all mushrooms contain a poisonous principle, the activity of which is greatly influenced by accidental conditions. In the preparation for eating he recommends treatment with boiling water, the water being rejected, this to be repeated several times, by which means the toxic principle is easily eliminated. It is said not to be present in dried mushrooms. —*Revue Médicale*.

**SUBCUTANEOUS INJECTIONS OF IODOFORM IN SYPHILIS.**—A solution of iodoform (6 pts.) in glycerin (20 pts.), of which from 30 to 75 centigrammes are used (gradually increasing) each time, is recommended by E. Thoman for hypodermic injection in intense syphilis. After six to twelve injections he always noticed a great amelioration in the symptoms. —*Bull. de Thérapeutique*.

**ULCER OF STOMACH TREATED WITH POWDER OF MILK.**—M. Debove recommends the evaporation of skimmed milk to dryness, and the resulting powder is given dissolved in hot milk (120 grammes of the powder corresponds to a litre of milk), in cases of simple ulcer of the stomach. To this some dry powder of meat may also be added. —*La France Médicale*, No. 18.

**THE CONFORMATION OF THE EYE OF A PROTEUS.**—In the arrest of development of a cyclopean eye it has been shown that the crystalline and vitreous bodies are wanting, it being simply the secondary optic vesicle. M. Desfosses has shown that this peculiar condition exists normally in the eye of the proteus. —*La France Médicale*.

DR. H. I. BERKELEY reports (*Maryland Medical Journal*, October 4) a case of tetanus following vaccination.



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PHILADELPHIA  
MEDICAL TIMES.

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PHILADELPHIA, NOVEMBER 4, 1882.

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EDITORIAL.

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PHILADELPHIA HOSPITAL.

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IN the Notes and Queries we print a communication from a correspondent concerning the recent affair at the Philadelphia Hospital. The facts of the case, stated briefly, are that Dr. Warder brought an etherized negress in labor into the public clinic, and delivered her with the forceps before some hundreds of students. The thirteenth day the unfortunate woman was seized with septicæmic metritis, and died in a day or two. Immediately after the delivery, the hospital committee threatened Dr. Warder with expulsion from the staff, but later on withdrew from such position. For this they are deserving of much praise, as practically to acknowledge a mistake requires the highest kind of manhood on the part of those who hold the authority and power. Whether it is or is not right to deliver women publicly, Dr. Warder had precedent for his action, and violated no existing rule, so that his expulsion could not have been justified.

We are not quite so sure as our correspondent seems to be of the propriety of these public deliveries. Modesty and tenderness towards women is a distinctly American trait, which has no general existence on the continent of Europe, where women of the higher orders command little respect, and those of the lower orders no consideration at all. We doubt the effect of such public obstetric clinics upon those who sit upon the benches of the amphitheatres. It must be remembered that these clinics are open to all the world, and not merely to medical students. If male and female genitals are to be frequently exposed, common decency requires that, by

issue of tickets, show of matriculation tickets, or in other way, attendance shall be confined to *bona-fide* medical students.

Further, there is a very especial reason why, at the Philadelphia Hospital, delivery should not be in the public clinic room. The women have to be carried nearly a quarter of a mile to a room situated between a ward devoted to erysipelas and a mortuary, which, when we have visited it, has often been more remarkable for its odor than for its cleanliness.

An assertion that all this does not increase the danger to the woman would be simply absurd. The long tolerance of these nuisances right by a room where the most delicate operations—even ovariectomy—are continually performed indicates an obtuseness upon the part of the surgical staff that is only accounted for by the years of villany on the part of the Board of Guardians, which long ago made the name of the Philadelphia Hospital a stench in the nostrils of all honest men, not lulled by the miasm of misrule which had settled about the whole institution. We wish the new board God-speed in their efforts to purify the Augean stables, and suggest two things,—first, that the erysipelas ward shall be removed to a safe isolation; second, that the so-called paralytic ward be removed from its present isolated position in the out-wards or Almshouse proper, where it practically does not get medical supervision, and be attached to the nervous ward, where it belongs. We have known sad cases of neglect and malpractice in these wards arising from putting patients away out of sight, seen only by new, and often ignorant, graduates.

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MEETING OF THE AMERICAN  
ACADEMY OF MEDICINE.

THE seventh annual meeting of the Academy of Medicine, just held in this city, appears to have been attended by such evidence of growth, material

prosperity, and sustained interest in its special work, as to give sincere satisfaction to its friends, and to offer much encouragement for the future. The papers read during the two sessions (October 26 and 27) were of decided value, and dealt principally with broad questions, interesting the profession as a body rather than concerning the details of daily practice, which so commonly engage the attention of our medical societies.

Besides the numerous papers read, the President, Dr. Traill Green, of Easton, delivered the annual address on Thursday evening, October 26, in which he reviewed the course of the Academy and its achievements, showing what changes had occurred since the Academy was founded, and in conclusion quoted from private letters the favorable opinions of various eminent men concerning the objects of the association.

Biographical notices of Dr. H. Lenox Hodge and Dr. Allen, the late president of Girard College, were read by the Secretary, and a report was presented by the Committee on Medical Legislation (Drs. Dunglison and Marcy), which was referred for publication, and the committee continued. In this report, when completed, it is intended to collate the laws of all the States with regard to the practice of medicine.

Among the pleasant features of the session was the receipt of letters from the surgeons in attendance upon President Garfield, acknowledging in warm terms and cordially accepting the resolutions of confidence and sympathy passed at the last meeting of the Academy. At the conclusion of the President's address, the Academy was entertained at the Colonnade Hotel by the Resident Fellows; and the occasion was so much enjoyed as to lead to the adoption of a resolution, before adjournment, authorizing an annual collation hereafter. The membership of the Academy amounts to over two hundred, and fifty-one new Fellows were elected at this

meeting. Drs. Henry F. Campbell, of Augusta, Georgia, and Austin Flint, of New York, were unanimously elected Honorary Fellows. The officers chosen for the ensuing year are—President, Dr. H. O. Marcy, of Boston, Massachusetts; Vice-Presidents, Drs. George M. Beard, of New York, William Elmer, of Bridgeton, New Jersey, Cornelius R. Agnew, of New York, and Thomas M. Drysdale, of Philadelphia; Secretary and Treasurer, Dr. Richard J. Dunglison, of Philadelphia; Assistant Secretary, Dr. Charles McIntyre, of Easton. The next place of meeting will be New York: as usual, the time will be the third Tuesday in September.

#### NEW YORK AND ITS ORGAN.

IF the *New York Medical Record* were as eager exactly to inform its readers of the true state of the case as it is to be puff New York City, its editorials would often be different from what they are. To be sure, a city which claims to be a medical metropolis, and yet has not a single first-class medical school within its wide domains, needs tergiversation sorely. With Harvard on the one side and the University of Pennsylvania upon the other, we wonder there is not pride enough in New York to start one school upon the higher plane. On second thought we cease this wonder, for New York did start one such school not long since, and maintained it just one year, when its stock of pride and conscience was exhausted.

These remarks are called forth by a recent labored editorial in the *Medical Record*, so worded as to give the idea that systematic post-graduate instruction was this winter, in New York City, inaugurated for the first time in this country. Really the *Record* presumes much upon the good nature or laxness of its readers in thinking they have never read the advertisements of Harvard University or of the University of Pennsylvania.

## JOHNS HOPKINS HOSPITAL.

IT is stated in the *Maryland Medical Journal* that the trustees of the Johns Hopkins Hospital propose opening that institution next autumn. The buildings, with the exception of the laundry, are all under roof, about one million three hundred thousand dollars having been spent upon them. In none of them has any inside work been done, other than flooring, staircases, and heating apparatus, and to finish during the coming summer will require active work. The buildings, when complete, will, in our opinion, be the finest of the kind in the world. The medical school may well be in operation two years before the hospital is in full activity. The course of instruction is to be extended over four years, and students will not be ready for practical bedside study until their third year. We are not in the secrets of the trustees of the University, but it is plain that the time is approaching when the medical faculty must be appointed. For the honor of our country, but especially for the good of the race, we trust the great opportunities now offered will be wisely embraced. With proper selections, Johns Hopkins University and Medical School may become a great centre of light and progress in the science and practice of medicine. The American intellect is equal to any in the world: what is needed is opportunity.

FAIR play and no favor has been repeatedly stated to be all that is desired by the friends of the women physicians in their competition with the sterner sex; but this principle was hardly exemplified last week, when the committee in charge of Blockley Hospital dropped a gentleman of the medical staff who had faithfully served and had long been identified with the institution, for the sole purpose of making room for the appointment of a doctress who desired his position. In order that the issue with the

profession might be fairly joined, the board passed a series of resolutions to the gentleman (whose sex appears to have been his misfortune, though not his fault), assuring him in complimentary terms that he lost his position not from any neglect of duty, nor from personal objections, but solely for the reason stated. Without discussing the obvious complications arising from a mixed staff, we merely observe that it is such questionable victories as this that injure the cause of true reform, and usually yield but a temporary and doubtful advantage to those who immediately profit by them.

## TREATMENT OF ASCARIDES LUMBRICOIDES.

—Dr. Guérmonprez sums up a long article on lumbricoides thus: (1.) Worm-seed (whose action is not to be confused with that of santonin) is by far the best medicament for killing, as well as expelling, round-worms. (2.) Santonin does not kill the worms outright; it excites them to livelier movements, and these may reflexly stimulate the intestine so as to expel them; but they may also only exaggerate the evil if there is obstruction. (3.) Santonin is, therefore, by no means always to be chosen. It does no harm if the worms are young and not numerous; if they are mature and many, it may be dangerous even in reasonable doses. (4.) The purgatives usually given with vermifuges probably do more than the latter to cause expulsion of the worms; simple evacuation will often suffice. (5.) Ordinary hygienic means directed to overcoming the lymphatic cachexia of the patient, or simple change of food and abode, may at times be enough to rid him of the worms without any medicine whatever. (6.) Hence our treatment should not be the mere routine administration of santonin, but should be determined by the circumstances of the case. Change of air and of diet, and simple evacuation, are not to be forgotten.—*Bulletin Gén. de Thérap.*, p. 89, 1882; *Praticien*.

REMEDIES FOR MALARIA.—“If you know your business, and it is a temperance town, you wink at the drug clerk, and say something about malaria. It is a matter of indifference just what you say. The single word ‘malaria’ is the golden open sesame. . . . Whenever I see a man coming out of a drug-store and wiping his mouth on the back of his hand, I realize to its full and awful extent the hold that malaria has on this unfortunate people. What the drug-stores in towns where a strict license law prevails would do without ‘malaria’ is a hard problem.”—*Western Ex.*

## LEADING ARTICLES.

## CEREBRO-SPINAL FEVER.

THE fact that cerebro-spinal fever tends to establish itself permanently, to become endemic, in regions in which it has prevailed epidemically, is so well recognized that it would, under ordinary circumstances, scarcely excite comment. Within a few weeks, however, two well-marked cases, of which one proved fatal, have fallen under my observation in private practice. It appears to me at this time worth while to give more than passing heed to the extent of the prevalence of this disease in our community, and to call to mind some general facts concerning the rise and extension of the great epidemics of the past. Cerebro-spinal fever with us, like typhus in Ireland, which has been compared to a smouldering spark, ready at any moment to leap into flame, may sweep from a few cases widely scattered to a destructive epidemic.

Stillé suggests that the history of cerebro-spinal fever during the present century may be divided into three periods, each of which comprises the account of a wide-spread prevalence of the disease upon both sides of the Atlantic, lasting for a series of years. The first of these outbreaks lasted eleven years, from 1805 to 1816; the second, thirteen years, from 1837 to 1850; and the third, which began in Europe in 1854 and in North America in 1856, came to a close in 1873, after a continuance of from seventeen to nineteen years, with, however, a period of repose in the United States from 1857 to 1861.

It is to be remembered, however, that in the periods of non-activity cases and even small epidemics of the disease have been observed, and that in recent years occasional limited outbreaks have led so careful an observer as Ziemssen to believe that the disease has become an abiding one in Europe.

There is thus some warrant for regarding cerebro-spinal fever as having had, during this century, a continued existence within certain geographical limits, as having had its periods of epidemic outbreak and its periods of quiescence, but never as having wholly ceased to exist within those limits, or as having disappeared in the same sense that cholera and influenza disappear from the same countries in the intervals of their epidemic visitation.

In looking over the Health Office Reports of this city, as far back as 1857, I find no deaths reported as due to this disease prior to the year 1863. In that year forty-nine deaths were ascribed to "spotted fever," forty-four of these cases being minors, five adults. In his report of that year, the health officer called attention to the fact that many cases of death due to cerebro-spinal meningitis were doubtless attributed to other causes, such as malignant fever, congestive fever, typhus, or malignant typhus, or merely fever, and to these we may safely add convulsions.

The table on the opposite page, compiled by Dr. C. F. Clark, is designed to exhibit the number of deaths returned for each year since 1860 as caused by cerebro-spinal fever and the affections with which fatal cases of cerebro-spinal fever have been most liable to be confounded.

This table is of interest not merely as showing approximately the number of deaths from the disease in question, but also as indicating in some measure the ignorance of its clinical characters prevalent among practitioners of medicine when it appeared in an epidemic form in this city, twenty years ago. Those who recognized it in 1863 designated it by the old and inexact term "spotted fever," a term which continued extensively in use the following year, but which forthwith fell into almost complete desuetude as soon as a familiarity with its constant pathological characters forced the profession to recognize the new-comer as a substantive disease, and suggested a designation embodying at once the idea of its infectious nature and the anatomical lesions.

That a great number of cases should have been classed under the heading "typhus fever" cannot be a matter of surprise when we call to mind the fact that cerebro-spinal fever was not at all known as a distinct affection until early in the present century, and that for many years it continued to be regarded by most practitioners and many learned writers on epidemic diseases merely as a variety of typhus.

Moreover, widely as they differ in many respects, these two diseases, viewed from the clinical standpoint, present many points of resemblance. They show us alike suddenness of onset, grave disturbance of the functions of the nervous system, fever characterized by a stadium



YEAR.	Cerebro-Spinal Meningitis.			Spotted Fever.			Typhus Fever.			Convulsions.			Malignant Fever.			Congestive Fever.		
	Adult.	Minor.	Total.	Adult.	Minor.	Total.	Adult.	Minor.	Total.	Adult.	Minor.	Total.	Adult.	Minor.	Total.	Adult.	Minor.	Total.
1860.....	0	0	0	0	0	0	10	6	16	11	263	274	0	0	0	1	0	0
1861.....	0	0	0	0	0	0	33	12	45	30	306	336	0	0	0	3	0	6
1862.....	0	0	0	0	0	0	25	12	37	40	663	703	2	0	2	7	1	8
1863.....	0	0	0	5	44	49	55	76	131	53	628	681	1	11	12	18	25	43
1864.....	27	117	144	35	205	240	149	186	335	40	696	736	13	63	76	14	63	77
1865.....	28	102	130	11	51	62	250	84	334	40	655	695	9	8	17	16	21	37
1866.....	18	57	75	1	16	17	68	28	96	34	663	697	2	2	4	11	9	20
1867.....	53	49	102	2	5	7	111	27	138	31	553	584	0	0	0	11	7	18
1868.....	12	42	54	1	0	1	83	25	108	35	669	702	0	0	0	7	8	15
1869.....	7	29	36	0	1	1	28	21	49	31	616	647	1	0	1	5	4	9
1870.....	5	31	36	0	0	0	47	22	69	52	681	733	0	1	1	5	2	7
1871.....	11	33	44	3	2	5	27	10	37	26	613	639	0	0	0	3	6	9
1872.....	36	92	128	2	3	5	25	10	35	36	716	752	0	0	0	6	2	12
1873.....	54	192	246	0	0	0	13	18	31	349	333	682	0	0	0	6	2	8
1874.....	14	68	82	0	0	0	17	9	26	23	654	677	0	0	0	3	1	4
1875.....	14	69	83	0	0	0	16	5	21	59	752	811	0	0	0	0	0	0
1876.....	17	67	84	0	1	1	10	8	27	83	811	894	0	0	0	1	1	2
1877.....	7	49	56	0	0	0	8	7	15	379	324	703	0	0	0	0	1	1
1878.....	16	74	90	0	0	0	7	2	9	16	678	694	0	0	0	1	0	1
1879.....	15	47	62	0	0	0	1	0	1	22	604	626	0	0	0	1	0	1
1880.....	8	70	78	0	0	0	17	3	20	20	717	737	0	0	0	0	0	0
1881.....	17	73	90	0	0	0	9	3	12	18	763	781	0	0	0	0	0	0
1882.....	...	...	...	41	...	...	...	...	...	...	...	...	...	...	...	...	...	...

41 Cases of Cerebro-Spinal Meningitis "to September 23."

of excitement followed by a stadium of depression, cutaneous efflorescences, a high death-rate, the tendency to epidemic outbreak. Regarded more closely, however, these resemblances are found to be only superficial, and the revelations of the necropsy show them to be due to pathological processes essentially unlike.

That the number of deaths ascribed to "malignant fever" should have been considerable in the early years of the epidemic can, in view of the well-known characters of cerebro-spinal fever, occasion no surprise other than that so vague a term should at any time have been regarded as admissible. It is to be observed that since 1866 only four cases have been so reported, and since 1870, none.

Pernicious intermittent fever, under which head is to be included the congestive form, may, with its fulminant manifestations, its speedy collapse, and fatal coma, be readily confounded with the so-called fulminant variety of cerebro-spinal fever. The diagnosis rests upon a consideration of the etiological factors of the two diseases.

The season of the year, a history of exposure in an insalubrious region, or the endemic or epidemic prevalence of ordinary intermittent or remittent fever, tend to clear up the obscurity arising from any accidental resemblance of the symptoms. Moreover, an attack of intermittent fever rarely declares itself as pernicious or ma-

lignant in the first paroxysm; it is only after one, two, or more seizures, differing not at all, or but slightly, from the common manifestation of the disease, that it discloses its true character.

The remarkable increase of deaths ascribed to this cause during the years of the epidemic prevalence of cerebro-spinal fever, as shown in the table, is due not to an association of the causes, but to confusion of the effects. It will be observed that since 1874, the year following the close of the epidemic as such, the number of deaths attributed to congestive fever has reached in all only five, against four for 1874, eight for 1873, and so on back. The total for 1863 was forty-three, and that for 1864 reached seventy-seven, a record so out of accord with our common experience as to warrant the assumption that most, if, in fact, not all, of these deaths were due to the then epidemic disease.

"Convulsions" constitutes so loose a category in mortuary statistics that I can find no inference deducible from this column in our table save this: that many different maladies in which convulsions constitute the principal morbid phenomenon or accompany the death-agony must be returned under this heading. This symptom, which must often be elevated to the importance of a diagnosis of necessity, is too often constituted a diagnosis of election.

Cerebro-spinal fever presents certain peculiarities in its mode of attack, its extension, its course and duration as an epidemic disease, that separate it widely from other epidemic diseases. It has more than once broken out with activity almost at the same time in the New and the Old World; in many instances it has appeared simultaneously at points as far distant from each other as the diameter of a kingdom, while the intermediate regions have remained free from it, not only while it prevailed in the regions attacked, but afterwards; and in general epidemics, such as have prevailed in Sweden, portions of Germany, and in districts of our own country, certain localities in the midst of the infected regions have wholly, or almost wholly, escaped its ravages.

This fever differs from other epidemic diseases also in its mode of extension. In general epidemics it has much more frequently been observed to spread by a series of isolated outbreaks of irregular distribution than by a direct advance from place to place or by radiating lines from an infected centre. This is not, however, an invariable rule, as is seen, for example, in some of the French epidemics, where the advance of the disease went hand in hand with the movements of troops, or where it corresponded with the course of a river, as in the epidemics which traversed the valley of the Loire, or in that great series of epidemics which passed over Sweden from the southwest towards the north, beginning in 1854, and raging fiercely and widely until 1861. Hirsch has pointed out this peculiarity of the Swedish epidemic,—that, starting from the province of Göthenburg, in the Skagerrack, in the southwest, it crept steadily towards the north, cases occurring in every season of the year, and districts affected one year almost wholly escaping the next; while the southern boundary of the new area visited by the disease corresponded very nearly with the northern boundary of that in which it had existed the year before. Strange to say, Norway wholly escaped until 1859, when the fury of the disease was beginning to abate in Sweden, and then experienced it only in circumscribed outbreaks. When, however, we trace the march of the disease more closely in these and similar epidemics, we are struck with the fact that its progress is still by a series of isolated outbreaks,—not,

in these cases, of irregular distribution, but in the general direction of the line of advance.

Not less remarkable is the course of the disease in an infected population. Its wide geographical distribution by no means represents a general diffusion among the inhabitants of the cities, districts, and countries in which it has prevailed. Scattered cases and groups of cases may occur over a wide area without any great tendency to a concentration of the violence of the epidemic, while, on the other hand, the whole number of cases may occur within restricted limits, and this is the common rule. Many epidemics have attacked a single class in the community. This was the case in France in 1837 and the following years, when the disease chiefly affected the soldiery, often being confined to a garrison or a section of a garrison, sometimes even to a single regiment, without extending to the surrounding populations; and in 1844, at Gibraltar, where the civil population bore the brunt of the attack. The same limitation of the cases to a class among the people was observed during the epidemic in Italy, where, in 1840, an outbreak at Procida was almost exclusively confined to the convicts in the galleys; in Ireland, where, in 1846, the inhabitants of the work-houses principally suffered; and in the late American war, at Newberne, at Memphis, and in the neighborhood of Washington, where the troops alone suffered.

Finally, this disease presents remarkable differences from other epidemic diseases, in regard to its duration as an epidemic. In this respect it has, at different places and in different outbreaks, shown the most extreme variations. Most of the epidemics have lasted from three to six months; others have been of shorter duration, coming to an end in a few weeks; while it has frequently happened that new cases have appeared throughout an entire year, or from the spring of one year till the end of the following winter. The duration of the epidemic depends upon causes not yet known. It cannot be said to be influenced by the size of the population; for on one hand we read of comparatively brief outbreaks in populous cities like Berlin and Vienna, and on the other of lingering epidemics in such relatively sparsely inhabited countries as Algiers and Sweden.

The epidemics are often, in spite of a

duration of several months or even of a year or more, limited to a relatively small number of cases in the infected community,—a few individuals here and there being attacked, and the mortality being moderate. In other instances, on the contrary, considerable numbers suffer and the death-rate is high, and, as Hirsch points out, the proportionate number of persons attacked and of fatal cases are not seldom in inverse ratio to the duration of the epidemic, a relatively great number of cases occurring, with a high mortality, in epidemics that came to an end in a few (six to eight) weeks.

Sometimes the outbreaks do not, as is the case with most epidemic diseases, rise steadily to an acme and then gradually decline, but seem to run an irregularly intermittent course, a number of persons being attacked, then the disease to all appearances vanishing, only, however, to return after a time to seize new victims, and this disappearance and return being repeated till the close of the epidemic, after many weeks or months.

Still more strange is the fact that cerebro-spinal fever once having appeared as an epidemic in a region previously free, may, and often does, take up its abode as an endemic disease. Our table clearly shows that it is at home in this community. Errors of diagnosis are not likely to occur: the disease has become a familiar one.

The cause of cerebro-spinal fever is as yet unknown. Much less is known of the laws which control its origin, its distribution, its action in communities and upon individuals, than is known of the active cause of the other infectious diseases. The unaccountable appearance of the disease at the same time in widely-separated localities, its diffusion by isolated attacks rather than by direct advance, its variable and often long-continued prevalence in epidemics, its sporadic occurrence between the epidemics, the extraordinary diversity of the symptoms in different epidemics and in different cases, baffle the comprehension and render futile every effort to formulate even a satisfactory hypothesis of its cause and origin.

Should it again become epidemic,—a danger not to be ignored, in view of the lessons of the past,—it is to be hoped that the improved methods of investigation now shedding light upon the nature of the cause in the infectious diseases will bring

to day the infectious principle of this fever, of all diseases the most erratic in its epidemic spread, the most protean in its clinical manifestations; a fever that well merits the term applied to it by the learned Stillé,—this “chameleon-like disorder.”

JAMES C. WILSON.

## CORRESPONDENCE.

### LONDON LETTER.

THE season has once more come around for the opening of the winter session at the various medical schools. A large number of hopeful youths come up to enter the curriculum which is to convert each of them into a wise physician, a bold surgeon, and a skilful obstetrician,—if they are only fortunate! How many per cent will fall out of the ranks before the student-march is over, it would be invidious to calculate. Preliminary examinations have driven away much of the hopelessness which once attached itself to a medical career. Of old, before the day of the matriculation examination, every idle fellow, when his friends were getting tired of his doing nothing and insisted upon his electing some career, decided to be a medical student. He could commence without any difficulty of examination; his studies would not be so severe at first; he could read up his Latin, and pass it, before any medical examination was due: after that he would proceed with his studies, like the rest. Hopes that perhaps were never very seriously entertained by the aspirant were not unfrequently never realized. The Bohemian life of a medical student was attractive; the social waif took kindly to it. Time wore on. The Latin was not passed, and the Bob Sawyer grew older and seedier, and ended either as an unqualified assistant to some indifferent practitioner in a low suburb, or made a new start, perhaps, as a full private in one of her majesty's regiments. But all that has been swept away, and belongs to the past as much as the resurrection-man. The medical student of to-day is a well-set-up youth, smart, gentlemanly, perhaps a trifle confident in himself, with a great impression as to the mystery of the human skeleton. He has passed his entrance-examination in a manner highly gratifying to his female relatives. His mother and sister are glad to be asked about him, and reply with conscious pride; while his old maiden aunt, from whom he has expectations, has sent him an affectionate epistle, with a five-pound note in, with a hint not to be extravagant in walking-canes, and has finally determined he shall occupy a prominent position in her last will and testament,—an instrument she will forthwith proceed to instruct her solicitor to execute. So

he is fully entered as a medical student, who can tell of the odors of the dissecting-room or the chemical laboratory, of the immense operation he witnessed without feeling squeamish, to the undisputed admiration of his old chums, who look upon him as certain to make his mark in the world. Yes, he will make his mark, only it would not be exactly easy to say what it will be in all cases. In most it is easy to prophesy a successful termination to the student career. The number who fall out "by the way" now is comparatively small, and when gentlemanly youths get into the police court they do not now pass themselves off as medical students, of whom such scrapes were rather to be expected and of which little notice need be taken beyond the infliction of the resultant fine. All that belongs to the past. This year the medical student has come forward freely. Farming is not very lively; with falling customs, trade is not as attractive as it was; but, despite the Sanitarian, disease holds its own, and therefore the prospects of doctors keep up. So the freshmen have been treated to the usual blend of welcome, good advice, and caution in the shape of the introductory addresses. One sad incident occurred in connection with these addresses. The gentleman on whom devolved the duty of delivering the address at the Middlesex Hospital died on the day his address should have been delivered. Dr. R. W. Lyell was a distinguished student at King's College; then he became tutor at the Middlesex, where he was a general favorite with his pupils. He was afterwards elected assistant surgeon to the hospital, and had before him a career full of promise. Ten days before the day of opening the winter session he was at the hospital, after which he felt a rigor. Pneumonia, the scourge of the overworked men, set in, and his career closed with terrible swiftness. One more lesson is thus taught by the medical profession,—that doctors just overwork themselves as much as the patients whom they lecture for it and advise. The address was delivered by Dr. Cayley, who had no time to prepare an elaborate address, and who entered his protest against "the arrest of experimental research" in Great Britain in the present day. "If Harvey had lived under Queen Victoria and the present restrictions, he never would have been able to discover the circulation of the blood." Well, there was little about the rule of the Stuarts to be thankful for, but it was well for Harvey in more ways than one that he lived under the reign of the "Merry Monarch." At St. Mary's the address was delivered by Dr. King Chambers, with whose charming writings all are familiar. Of course our expectations soared high when we learned that Dr. Chambers was "bidding farewell to his old chair, which illness prevented him from doing years ago." We think of some beautiful

addresses by him in days gone by. We hope to hear another like them, and find that, for reasons of his own, he has selected as his topic "The Relation of the Medical Student to the General Medical Council." He is the junior member of that august body, "whose most important duty was to watch over the student," to see that he got the value of his money, and speed him on his way to become "a useful and honored Englishman." He made out a good case in contrasting the student of the present day with the Dick Swiveller type of the past.

After their students' days were over they might become "assistants" to practitioners, but not before. He then delivered himself of some trenchant remarks on the "unqualified assistant," and the persons who tempt men to become such. "They do it for their dirty profit, and it is a very bad bargain for you." This is very unlike the stately, indeed, courtly, language of Dr. Chambers ordinarily; but, like other folks, he finds a difficulty in applying choice language to unsavory subjects. He expressed a strong belief that "the catechetical method of teaching" must largely take the place of the formal lectures now in vogue in medical teaching. "The quiz class" is coming more and more into fashion everywhere, both as a means of teaching students and an education to them to express themselves. Dr. Chambers thought this much better than "sitting out" a stated number of lectures, as it did not keep the working man tied down to the sluggard. If a student could stand the cross-examination on any subject, then he could devote his time to something else. He then took formal leave of the school where he first lectured before the plaster was dry upon the walls.

At St. Thomas's, Dr. Sharkey referred to the early history of medicine, when it was in the hands of the priest; then to times when it bloomed out into flower, "warmed by the glow of some enthusiastic genius," to fall back again for long years. Physiology has made modern medicine, he asserted. It had, too, done much for treatment. "We have thrown down the idol of universal specifics, which men had hewn out of false conceptions of disease. We have set up in its place rational scientific treatment, founded upon the knowledge of physiological processes in health and in disease;" while our acquaintance with the action of drugs enables us to wield them with more precision than was possible in the past. The scepticism as to specific remedies for all maladies which was the natural outcome of such direction of thought was not, he held, an evil, provided it were not carried too far. Men did not heap up a lot of different ingredients in a prescription nowadays, but wielded their remedies rather "as arms of precision," compared to the "mitrailleuse system" of former days. He thought the days of "systems of medicine,"



of "pathies" of all kinds, numbered, and that the day of the scientific study of medicine had dawned.

At University College Hospital the address was delivered by Mr. Marcus Beck, assistant surgeon thereto, a fact which drew a larger attendance. Mr. Beck is quite worthy of his school, which is pre-eminent in medicine the world over. He referred to the surgeon-apothecary of past times, with his education of apprenticeship, like any other craftsman. But early in this century these men set on foot a movement which led to an act being passed in 1815, after which every apothecary must receive some distinct medical education. Since then the standard of examination had steadily risen. He thought some knowledge of botany and zoology very desirable for a medical man, as part of the mental training requisite for a practitioner. He held, however, that the real study of these subjects was often delayed by the student till it became a case of "cram" at last, which deprived it of its value as mental training. It was not, however, he held, desirable to prolong the course of medical study till it was placed beyond the reach of many men who wished to study medicine. As to those who asserted that the value of mental training in medicine was small, it was unnecessary to confront them. The advances made in surgery in the last twenty years were acknowledged on all sides. If the student could pass his entrance-examination at sixteen, he would be usefully engaged on botany and zoology till the next year, when he might begin the study of medicine proper. He thought it as desirable to protect the student against "the irregular and unscientific course of study that he is too often allowed to pursue" by proper examination, as it was to protect the public against ignorant practitioners.

At St. George's, Dr. Herbert Watney took much the same line, and spoke of the study of "materia medica" as compared to "pharmacology" as a case of "survival,"—an opinion with which few will disagree. "A scientific education implies study with a view to the acquisition of knowledge apart from any ulterior object; practical education implies the study of any subject in such a manner that we can bring our knowledge to bear at the present or any future time." He went on, "Science is not liked by some, because it makes so little of the individual opinion, and treats so lightly that power which some men have of enforcing their views and persuading their fellow-men. In politics and in art we see the immense influence of the individual,—how his word is taken almost as law; yet the habit of accepting without question what is told us has been the most fatal stumbling-block to the advance of medicine." In the Middle Ages the shadow of Galen hung over medicine, and the men engaged themselves "seeking rather to conquer their opponents

in argument than to penetrate the secrets of nature." Now we have a better scheme. "At last we are driven to the conclusion that medicine is a progressive science, and that we are profiting by the information obtained by others, reaping the fruit sown by them at great expense, after many failures and much disappointment." He told them, "It is very necessary that you start with one humbling thought,—that you cannot finish your studies, and that you must go into practice to a certain extent incompletely prepared." But the consciousness of such incompleteness will spur men on to attain the perfection or fulness of knowledge, or, at least, to attempt to do so.

At King's College, the Right Hon W. H. Smith gave away the prizes. After pointing out that the English achieve their great ends by having sound minds in sound bodies, he went on to say that the duty of a doctor, in his opinion, was to go beyond the position of a medical adviser, and to become the friend of his patient. In this way he could often do more than by the mere administration of medicines and drugs. Tact and judgment, he felt certain, existed now to as great an extent as they did formerly. Truth he recommended to medical men in dealing with their patients, and he recommended it as one who had passed the summit and was going down-hill. When a man had obtained a reputation for truthfulness, any hope he might hold out was almost the best kind of tonic that could be given, but, on the other hand, the medical man who was known to give hope when there was no hope lost much of his power. (To whom the Right Honorable gentleman referred in this last sentence is unknown to the writer. It does not apply to any of the well-known heads of the profession, that is certain. Possibly it applies to a brood of medical parasites who cling to the skirts of the socially great, but who are practically unknown to the profession.)

At the London Hospital a conversazione was held in the evening, when Jonathan Hutchinson gave an address which was mainly about Carlyle. He spoke of Carlyle's antipathy to Darwin's views. He was too impatient, he said. "The truth is that what Carlyle himself was proclaiming in the language of the mystic, Charles Darwin was explaining in the language of science. Carlyle was asserting that there is a spiritual power in nature, was bidding us reverence that power as supernatural, and as working, through rough and mysterious ways, towards certain and definite good. Darwin, looking at the same facts from a biologist's stand-point, explained how this result did indeed come about, and that, too, through the simplest and most un-mysterious ways." Then he went on to point out how the ideas of Wordsworth and of Browning harmonized with the principles of Darwin, the whole telling that even the wary, cautious surgeon and philosopher no longer thought

it unsafe to consider Darwinism and evolution before a mixed company at a medical conversazione.

At the Leeds School the address was delivered by T. R. Jessop, a worthy scion of the school of the Hays and Teales. He preferred to take a bird's-eye view of the recent progress of surgery. He said that these improvements were at least synchronous with the teaching of Lister. Even in such a matter as scirrhus of the breast, cases which but a short time ago would have been dismissed as "too late" were now operated upon, and deep dissections were now rendered possible by the aid of antiseptic precautions, and compatible with life and the healing of the wound, that recently would have been regarded as unjustifiable. As to cancer elsewhere, its removal soon and completely was becoming possible even in the interior of the body. Left lumbar colotomy was now an operation no longer formidable. Bones were now cut and chipped with chisels safely. It was no longer a matter of dread to lay open a joint if desirable. He said, "In the days of festering wounds, when phagedæna (of which I hardly see an example now) was a perennial visitor in our wards, when pyæmia and septicæmia marred the statistics of all our hospitals, the risks involved in the presence of a wound communicating with injured bone were so terrible as to forbid the surgeon from voluntarily inflicting a compound fracture to obtain a merely æsthetic result." Now all this is changed. Repeated osteotomies are performed without hesitation for deformities. Cleft patellæ are wired together, healing kindly. Loose cartilages are fished out of joints. Kidneys are extirpated; but this operation is still a very serious one.

Such, then, was the recital of what is being done at one of our best surgical schools; such the modern triumphs. Listerism was tried on the field of battle in the recent campaign in Egypt, and with success; and the new method of treating surgical wounds is enabling much to be done successfully that even in modern times would have been thought out of the question. These addresses to students interest their seniors little, may seem commonplace, for much that is novel cannot be expected, yet they are useful for the impression they make on the students' minds at the threshold of a new phase of their existence.

J. MILNER FOTHERGILL.

**HIGH TEMPERATURE IN BELLADONNA-POISONING.**—A case is reported in the *British Medical Journal* for September 23, of a fatal case of poisoning in a child from eating the berries of the deadly nightshade. The narcotic symptoms appeared two hours, and death nineteen hours, after eating the berries, being preceded by coma and a temperature of 110° for several hours before the fatal result.

## PROCEEDINGS OF SOCIETIES.

### NEW YORK ACADEMY OF MEDICINE.

STATED MEETING, OCTOBER 19, 1882.

DR. FORDYCE BARKER, President, in the chair.

THE scientific paper of the evening was read by Dr. T. E. SATTERTHWAIT, and was entitled "*The Origin and Natural History of Tuberculosis.*"

The study of tubercle had always attracted profound interest chiefly because of the close relation it holds to pulmonary consumption. The most notable advances in its study had been made in the present century. The names of Bayle, Baillie, Laennec, Louis, and Rokitansky in the earlier half of the century were connected with a number of facts in the history of the disease, but it would seem probable that the researches of the last fifteen years surpassed them in thoroughness, exactitude, and practical utility. This might be accounted for by the fact that the older writers based their work almost exclusively on morbid anatomy, while modern workers had utilized both pathological histology and experimental pathology. "Let us," said the author, "take up the history of the subject with a view to determining the vital questions which are at issue, and which centre about—first, the histology of phthisis; second, its unitarian, dual, or plural nature; third, its so-called infective qualities; fourth, the mode in which it originates; fifth, the intimate nature of the presumed infecting agent."

He used the word tubercle as meaning the miliary tubercle, the pearly or gray granulation of Bayle or of Laennec. It seemed to have been first described by Mangetus. Laennec stated in 1819 that tuberculous matter occurred either under the form of insulated bodies or of an infiltrated substance. He did not consider tuberculosis (pulmonary) as inflammatory, nor that pneumonia was transformed into phthisis. Reinhardt, however, soon challenged these views, and had little difficulty in demonstrating that the so-called infiltrated tubercle had properties which would naturally belong to an inflammatory deposit undergoing cheesy transformation. Virchow accepted Reinhardt's discovery, and repudiated the statement that there was any so-called tubercle which was not of the miliary variety. He also demonstrated conclusively that the yellow infiltrated or crude tubercle might originate from inspissated pus or encysted parasites. But it was often impossible to trace any genetic relation between miliary disease and certain forms of phthisis, and the adherents of the unitarian theory naturally sought for some other cause, and gave room for the doctrines of Niemeyer, who attempted to connect phthisis with pneumonia, of which it might be a natural sequel. Buhl, however, soon succeeded in turning

opinion back to the French school by showing that bodies resembling tubercles in their gross and microscopic appearance might be produced in animals by the presence in the body of certain centres of infection,—cheesy foci.

Dr. Satterthwaite then reviewed the subject of experimentation on animals by different investigators, regarding the ingestion of tuberculosis matter, its inhalation in a state of minute division, also the inhalation of Limburger cheese, of powdered bran, etc. The following were some of the conclusions reached: that there was one class of experimenters who claim that the inoculation of phthisical matter produces a specific disease, among whom were Villemin, Gerlach, Tappeiner, Weichselbaum, and Baumgartner, and also at present Cohnheim; while among those who do not believe in a specific virus are Fox, Burdon Sanderson, Sir Andrew Clark, Schottelius, Scheuppel, and Wargusini. This truth remained, that observers of the highest reputation had recorded results from the same series of experiments diametrically opposed to one another. Clinical facts did not aid us materially, for, while it was claimed that communication of phthisis frequently took place among cattle by cohabitation, it was to be remembered that the tuberculosis of animals was in several ways distinct from that among men, and the evidence of those who had a large experience in consumptive hospitals was not favorable to the contagion theory. We therefore seemed justified in claiming with Virchow that neither "experiments nor clinical observations up to the present moment have furnished any decisive facts." Wolfe had recorded a case showing that a simple traumatism of the eye in an apparently healthy child set up milinary tuberculosis that led slowly but steadily to systemic infection. He referred to the experiments of Prof. Siedamgotsky on the question "Whether and how far the use of the meat and milk of cows which have the pearl disease or bovine tuberculosis is harmful to human beings." This gentleman felt justified in concluding that his experiments yielded no result giving any positive support to the statement that tuberculosis can be conveyed to mankind through the milk or meat of tuberculous cattle.

The author considered Koch's theory in support of the doctrine of a specific parasite in tubercle, this investigator claiming to have found a peculiar microphyte in every form of tuberculosis. He gave the results of some of his own investigations in this direction, and then took up the question "Is Tuberculosis Hereditary?" finally closing his paper with the following conclusions, drawn from his study of the subject of tuberculosis:

1. Tuberculosis is a disease that fairly deserves the name hereditary, for it attaches itself to certain families throughout many successive generations. It is most apt to at-

tack those members who are deficient in physical vigor from whatever cause.

2. The most distinguishing characteristic of tubercle is the occurrence in the tissues of minute, bright, glistening, translucent particles, that have been called milinary tubercles, granula, granulations, etc.

3. They are the result of an inflammatory process, because they can be produced by the introduction of mechanical irritants into the system.

4. When these minute bodies coalesce to form larger bodies and undergo a change of color, they are known as crude or yellow tubercles.

5. Some of them contain the reticulated tissue that has been called adenoid, because it resembles the retiform tissue of lymphatic glands. As the milinary tubercle advances in age, one or more large multinuclear foci may be found either at the centre or periphery of the nodule. Sometimes Scheuppel epithelioid corpuscles are found, sometimes lymphoid elements, and sometimes fibrous tissue; but no one of these tissue-elements, which belong to the connective-tissue series, is pathognomonic of tubercle.

6. The lungs and serous membranes are most frequently attacked, and it is here that the natural history of tubercle is studied to the best advantage. In other regions of the body there may be modifications of the tubercle, so that its distinctive character is difficult to demonstrate.

7. In the gradual development of these bodies they undergo caseous change at the centre, which phenomenon is another marked feature of tubercle. Still, in some instances we have reason to suppose that the milinary tubercle may become organized, and thus a cure result.

8. Tubercles are rarely found without more or less contiguous inflammation, which, within the lungs, may be classed as a pneumonia. It is the infiltrated tubercle of Laennec, the catarrhal pneumonia of Niemeyer, or the desquamative pneumonia of Buhl. It may perhaps be protective in some instances, serving to wall off a caseous process, thus preventing it from becoming disseminated, or it may eventually itself participate in the same process, and lead finally to necrosis of the lungs and the production of cavities.

9. Tubercles may be confined to a limited area and a single lobe of the lung, or a single lung, or they may be diffused pretty equally in different organs. Generalized, disseminated, or secondary tuberculosis is the most dangerous and malignant, and is probably due to transmission of the disease by the lymphatics or blood-vessels, usually the latter. In this secondary form the first manifestations are the gray granulations, as they are also in the primary form.

10. Tuberculosis is inoculable, producing its kind if it produces anything, but other

substances will also, in a certain number of cases, produce the same apparent lesions; in fact, not only any organic substance that is capable of physical deterioration, but also a variety of non-organic substances.

11. There is some good evidence favoring the theory that consumption is contagious,—*i.e.*, that it is capable of propagation by cohabitation, or, in other words, close association, with persons who have the disease.

12. The morphological differences between the form of phthisis of the domestic animals and that of the human being are such as to put us on our guard against forming hasty conclusions from a comparison between them.

13. It does not appear that we have good grounds for believing that the meat or milk of phthisical cattle when taken as food has ever produced a single instance of tuberculosis in the human being.

14. But we should none the less discountenance the sale of such meat or milk, since, even if they are not infectious, they are deficient in proper nutritive elements, and for this reason alone should be debarred from sale.

15. And so in the case of bovine virus, though it does not appear that any person has been rendered tuberculous, yet no vaccine virus should be held to be suitable for vaccination purposes unless proper assurances are given that the animals yielding the vaccine were in every respect free from tubercle, as determined by inspection after slaughtering.

#### DISCUSSION.

Dr. DELAFIELD said his own interest in tuberculosis had been chiefly with regard to its morphology. It had seemed to him that there was a definite anatomical product which might be called tubercle-tissue, composed of basement substance and cells. It did not differ essentially from other inflammatory products of connective tissue. Such tubercle-tissue was by no means identical with miliary tubercle. Miliary tubercle simply expressed the gross appearance of certain little nodules found under certain circumstances, some of them composed of tubercle-tissue, and others not. He believed that inflammatory products might be so arranged as to form either miliary tubercle or diffuse inflammation. The study of tubercle was always complicated by the fact that tubercle-tissue, granting there was such a thing, was scarcely ever produced by itself, but was almost always present in combination with ordinary inflammatory products, acute, or chronic, or both. So far as he knew, pulmonary phthisis never occurred in adults without the production of tubercle-tissue, with one exception, namely, pure interstitial pneumonia. Ordinary chronic pulmonary phthisis in the adult was accompanied with such an amount of tubercle-tissue as to give one the idea that this was the essential part of the process, although there were present complicating inflammatory products.

Dr. JACOBI did not believe that Koch's theory concerning tuberculosis was by any means proved: it was only another parasitic theory, such as had been presented many times. He was inclined to believe that tuberculosis and phthisis were two distinct diseases. This much was certain, that there were many cases of tuberculosis without phthisis, and many cases of phthisis without tuberculosis. That view did not include that the two diseases could not exist in the same individual, nor that tuberculosis might not become phthisis, nor that phthisis could not become tuberculosis. In opposition to the parasitic theory was the fact, as had been mentioned by Dr. Satterthwaite, that according to many observers a diathesis was always necessary to the development of tuberculosis or phthisis. Some called this scrofula, and the old question whether so-called scrofula or tuberculosis or phthisis were not essentially one and the same process was not at all settled. There were other important facts to be borne in mind, as that of phthisis occurring in persons in whose families there was no hereditary diathesis. Some children, in whom the sterno-vertebral diameter was too short, were almost predisposed to suffer from phthisis in later life, although there was no tuberculosis or phthisis in other members of the family. Again, there may have been no phthisis in a family for generations, but there was syphilis, and a baby born under such circumstances was liable to have glandular swellings, as of the bronchial and tracheal glands, which gave rise to a cough by irritation of the mucous membrane of the bronchi, with which they were intimately related, and the final result might be phthisis. Measles and whooping-cough were frequently accompanied by broncho-pneumonia, and tuberculosis or phthisis, or both, made their appearance. The facts thus far brought forward were not sufficient to convince him that the bacillus must be in every case present as the cause of phthisis. The view that tuberculosis and phthisis were one had an important bearing upon the treatment. It was true that in some cases a vicious constitution must be attended to; but in a large number of cases preventive treatment was entirely local. He did not believe that morbilli and whooping-cough should be left to themselves simply because they were self-limited diseases, since if they were allowed to run their full course there would be opportunity for broncho-pneumonia to develop. It was also an interesting fact that tuberculosis and phthisis were seen at different periods of life,—phthisis with or without tuberculosis in later life, and tuberculosis in early infancy. Beneke had found that the pulmonary artery in the infant was very much larger than the aorta. This relation between the two vessels changed after some years. Relatively the right heart was more powerful than the left at this early age. These facts might go to explain why the lungs of babies



were so much more liable to cedema and to the development of catarrhal processes than were the lungs of adults. These facts should be studied as much as the bacillus question, and they might prove productive of as good results.

Dr. W. H. WELCH thought Dr. Satterthwaite's paper showed that recent investigations tended to establish the fact that pulmonary phthisis was essentially tuberculosis. Niemeyer's doctrine that tuberculosis plays a comparatively unimportant rôle in phthisis, that catarrhal pneumonia undergoes caseous degeneration, and so produces phthisis, at present receives but little support from histological and pathological investigations. Both histological and etiological investigations, conducted independently of each other, led to the conclusion that phthisis was essentially tubercular in character. He entertained the same views that Dr. Delafield had expressed regarding the morphological changes, and believed that miliary tubercle was the most important anatomical criterion of the tubercular affection. Within the last few years histological observations had shown that the diffuse changes which occur in phthisis are as much tubercular in character as are the miliary tubercles. What was known as caseous pneumonia, or scrofulous pneumonia, etc., had been determined to be the special result of the tubercular process; and that it presented histological structures which allied it to miliary tubercle was, he thought, an established fact. He believed that the inoculability of tuberculosis had been established. His observations concerning the bacillus of tuberculosis had been confined mostly to the sputa of pathological patients, and he had been surprised at the uniformity with which the bacillus was found, but he had not always found it in the lung-tissue itself. He did not think the clinical facts which had been brought forward in opposition to the infectious theory of phthisis were of sufficient weight to justify us in discarding the exact experiments and observations of Koch and others. With regard to the question of heredity, it should be remembered that phthisis itself was not inherited. That which was inherited was only a lack of resistance to the special poison of the disease. Certain persons, such as Dr. Jacobi had mentioned, possessed a less degree of immunity against phthisis than others. The same was true regarding typhus fever and other diseases. The multiple forms of phthisis had been regarded as a strong objection to the opinion that tuberculosis and phthisis were identical; but it should be remembered that a regular succession of events was frequently absent in other affections, as in syphilis. This was also true of experiments regarding inoculability.

Dr. SATTERTHWAITE was surprised that there was such uniformity of opinion upon the subject of tuberculosis, for five or six years ago nearly all entertained different

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opinions from those which had just been set forth, and believed that miliary tubercle was a distinct disease from the catarrhal phthisis of Niemeyer. It was an important fact that those gentlemen who took what might be called the histological side of the subject were, it seemed, unanimously of opinion that tubercle was an inflammatory product. Regarding the question "Is Phthisis always Tuberculosis?" he thought possibly he would not take so strong ground as Dr. Welch had taken. He was not quite sure that phthisis was always tubercular. He had been told by competent observers that a pneumonia occurred in the colored race which went on to a caseous change without being associated with tubercle. Niemeyer had put us astray by claiming that tubercle was always preceded by caseous pneumonia or by some deposit of caseous matter in the body. This was incorrect, for miliary tuberculosis was found without pneumonia, and in some other cases most careful search for caseous deposits in other parts of the body failed to reveal any. With advancements made in the study of tubercle, corresponding advancements had been made in the study of scrofula. Scrofulous disease of the glands was now classed under the head of tuberculous changes. Perhaps we should so class those sluggish forms of disease in which the lymphatic glands become enlarged, the bones become involved, and inflammations of the mucous membranes and skin manifest themselves. He was of opinion that the direct influence of contagion was slight in comparison with the hereditary taint.

#### PHILADELPHIA COUNTY MEDICAL SOCIETY.

A CONVERSATIONAL meeting of the Society was held at the hall of the Society, September 27, 1882.

#### DISCUSSION ON ABNORMAL OBSTETRICAL PRESENTATIONS.

Dr. D. M. Barr thought the subject of placenta prævia was a most important one, it being a matter of life and death to mother and babe, depending largely upon the prompt presence of the medical attendant.

He recalled the care with which Dr. Ellwood Wilson dwelt in his lectures upon the management of these cases throughout gestation as well as at the period of labor. It was always advisable for the attending physician to arrange with a brother practitioner living within easy reach, so that any emergency might receive prompt attention. He detailed a case in which, owing to his late arrival, severe hemorrhage had occurred; the placenta was already detached, except a portion still adherent to one side of the cervix: this was promptly separated, and the child expelled in a few minutes, and the hemorrhage arrested, but so severe had been the

bleeding that the patient was almost bloodless, and in a fainting condition. There was no one in the house but himself and patient, and neither time nor means to obtain remedies. Pressure was made upon the abdominal aorta, with a view to retain blood in the upper portions of the body, with, he thinks, good effect, and patient speedily reacted.

In the anæsthetic recommended by Dr. Taylor, he thought the proportion of chloroform too large: he preferred one part of chloroform, three of ether, and two of alcohol. Such a mixture causes no nausea, relieves the pain promptly, with less profound anæsthesia, less liability to hemorrhage, and with consequently greater safety.

Dr. Montgomery agreed with Dr. Smith as to the great benefit derived from abdominal palpation. Were this procedure in all cases the rule of practice rather than the exception, many cases of malposition would be determined prior to the inception of labor long before they can be disclosed by vaginal examination, and the condition rectified, or the practitioner prepared for the imminent danger to mother or child.

In all cases of doubt it should be practised in addition to the vaginal exploration, as it will throw much light upon the position of the fœtus. Thus, in occipito-posterior positions the feet and limbs will be felt through the abdominal wall on either side of the median line; in occipito-anterior, the back of the fœtus can be outlined and the heart-sounds heard below the umbilicus on either side. In breech presentations the hard, resisting head is felt high up, and the heart-sounds are distinguished above the umbilicus. Transverse presentations are as easily determined.

In one case, three weeks before delivery he was able to foretell the birth of twins by distinguishing two heads through the thin abdominal walls.

Of vaginal exploration and abdominal palpation, the latter is capable of affording us the more satisfactory information.

Dr. McFerran said that if the views of Dr. Smith opposing an attempt to change the position of the head from a posterior to an anterior one were correct, it raised the question of the utility of a circumstantial and close diagnosis, and any law like that said to be proposed by Tarnier in France would be a useless refinement. In estimating the value of the procedure advocated by the author of the paper, the personal advantage of small hands should not be lost sight of, for in obstetrical operations no equality exists between the use of the finger and hand. He who can gain access to the part with the hand may accomplish that which seems impossible to those who, from the nature of things, never had any experience in the matter. Such being the case, it was easy to believe that the author of the paper had been successful in the mode of procedure, and others, equally skilful, have failed.

Dr. W. S. Stewart inquired if Dr. Smith had ever used the hot-water douche with success in placenta prævia. He would not like to try it, on account of endangering the life of the fœtus. He could not condemn the tampon when there was no escape of the liquor amnii. He had treated successfully by the tampon saturated in a solution of Monsel's salt, and also with equal success by injections of a strong solution of the salt given repeatedly as the necessities of the case might require. He would also indorse the reference made by Dr. Smith to palpation and auscultation as a very valuable method in diagnosing the position of the fœtus in utero, which the author of the paper omitted to mention.

Dr. Dunmire had found great difficulty sometimes in changing the position of the head by manipulation. Though frequently succeeding, he had in one case of face presentation failed to bring the vertex down. The membranes had ruptured, the chin to the right, afterwards rotating into the hollow of the sacrum. Applied the forceps and delivered the child. It gasped twice, and died. He had successfully managed a case of prolapse of the cord by keeping it up for two hours with his hand until a pain brought down the child's head, engaging it so as to shut the cord out of the way of danger.

Dr. Toboldt had found little difficulty in changing the position of the head. In one case he had changed the position of head while the os uteri was pretty well dilated, after which a single pain expelled the child. He had also changed the position by external manipulation. He had used injections of Monsel's salt to control hemorrhage, and had no fear of using it even at full term.

Dr. Chestnut detailed the case of a patient with placenta prævia who had lost much blood and had been in labor for some time. He employed a method of treatment which he had not heard mentioned in the discussion. He had forcibly dilated the os uteri (which at the time was about the size of a quarter dollar), using at first his fingers, and then forced the index finger, and after it the hand, directly through the body of the placenta, ruptured the membranes, turned the child, and, using it as a dilator of the os, brought it down and delivered it. The placental mass was then removed. Some bleeding occurred, but not much. The case ended well. He referred to the case partly that the method might be criticised, in view of the consideration that, whilst it gave the greatest safety to the mother, it afforded least hope to the child. In the case cited, he believed the child to be dead.

Dr. William T. Taylor, in closing the discussion, said that he fully approved of Dr. A. H. Smith's remarks about abdominal palpation; but, although it would be a satisfaction to know if it is a twin pregnancy, or that a head or a breech will present, yet when labor

begins, the management of the case must be as has been described.

The cases in which the head was delayed are those of "retarded dilatation of the os."

With regard to the danger of turning the body from a posterior to an anterior position, he could not recollect that any accident had occurred from it in his hands.

Dr. Smith had said that "nature never rotates above the brim of the pelvis, and therefore the accoucheur should not try to do so." But to that he would answer that we may expedite and aid nature, much to the advantage of the patient. He had detailed cases (in a former paper read before the Society) in which labor had been shortened by such expedients.

In regard to the danger of internal hemorrhage in using the tampon, he thought that the attentive physician would soon notice the signs of such a condition, the weak pulse, pallid lips, gasping breath, etc., and he would give restoratives and remove the tampon; but he had never had such unfavorable result in his own use of the tampon. He would hesitate to use the hot douche, being somewhat afraid of it.

How Dr. Barr could compress the abdominal aorta in cases of placenta prævia, when the uterus contained a child, he could not understand.

In Dr. Dunmire's case, the chin was probably below the promontory of the sacrum, and the forceps were the only remedy.

In his paper he had referred to the dilatation method of which Dr. Chestnut had spoken.

## REVIEWS AND BOOK NOTICES.

TRANSACTIONS OF THE AMERICAN GYNÆCOLOGICAL SOCIETY. VOL. VI. FOR THE YEAR 1881-82. Philadelphia, Henry C. Lea's Son & Co., 1882.

Dr. Byford, in his introductory, claims for gynæcology the distinction of an "associate branch of medicine," placing it upon the same footing as surgery and practice, and considering it as "more comprehensive than either." He adds, "The restricted appellation of specialty cannot be applied to it as it now stands." So that at one fell swoop, as it were, the dragon of gynæcology has swallowed up all branches of medicine, and sits glaring defiance at our noble profession.

Dr. Byford's address would serve as a model for the ideal Fourth-of-July orator, and he lays aside his eagle's pinions only when urging the propriety of perpetuating in some way the memory of Ephraim McDowell, the father of ovariectomy. He suggests a fund for annual prizes and lectures, to be raised by a novel plan, each ovariectomist contributing five or ten dollars out of his fee for each ovariectomy. This, he says, "would

not bear heavily on the operator." Oh, no! Our own idea, looking at this vast, inexhaustible field from which contributions can be drawn, and the magnitude of the sum that could easily be raised, would be to erect a McDowell monument: it is more American, —i.e., if it is crude and unfinished. It could be immensely high, and the bronze casting, representing Ephraim holding aloft the successfully-removed specimen, would therefore be so distant that it would be less likely to "bring a blush to the cheeks of the young person," if the young person be not by the time it is finished so generally spayed as to be beyond blushing.

Dr. Samuel C. Busey's paper on acute hyperæsthesia of the peritoneum, etc., elicited in discussion a decided opinion against a loose method of naming pathological conditions, one speaker acknowledging that gynæcology is "becoming very much burdened by new terms."

Dr. Henry J. Garrigues read a paper on exploratory puncture of the abdomen, based upon ninety-four cases, both "operative and tapped." Of "Drysdale's corpuscles" he says, "they are not only not pathognomonic of ovarian cysts, but they do not even prove that the fluid examined has been taken from any kind of cyst." The result Dr. Garrigues arrives at is "that there is no pathognomonic morphological element in the fluid of ovarian cysts," but that generally he is "able, by mere examination, to distinguish an ovarian fluid from any other."

Dr. G. H. Lyman's paper is upon "Pelvic Effusion resulting in Abscess," and is based upon one hundred and forty-six cases, observed in the Boston City Hospital, between 1875 and 1880. He advocates early puncture.

The paper entitled "Genital Renovation by Kolpostenotomy and Kolpoecetasis in Urinary and Fecal Fistules," is by Nathan Bozeman, M.D. It presents us in its first pages with the spectacle of the birth of a new word, for, following the example of the ophthalmologist, the gynæcologist is now striving to bar the entrance to his specialty with mighty names. The reader of this paper must encounter and overcome cystostelosis, kolpokleisis, kolpostenotomy, kolpoecetasis, kolpostenosis; and when there are thrown in a few other big words from outside sources, as pyonephrosis, etc., it is still more bewildering. Hystercystokleisis is a good word, if it stops growing now. Then we have hysterokleidic, episokleisis, anakainosis. "Some may object," the writer says, "to the introduction of so many new words;" but the introduction is a small matter: the difficulty is in recognizing them the next time one meets them in literary circles.

Dr. Ely Van de Warter's paper is upon "Forcible Elongation of Pelvic Adhesions." It elicited much adverse opinion in discussion.

Dr. Isaac E. Taylor contributes an article on "Lupus or Esthiomène of the Vulvo-Anal Region."

Dr. Goodell's paper on "Bursting Cysts of the Abdominal Cavity," apart from its technical interest, shows how a tumor may be discovered by one observer, and in a day be pronounced a "phantom" by another equally good observer, and incidentally the author throws some side-light upon the nature of those reported cases of menstruation and conception after the supposed removal of both ovaries, which have passed so long in the character of "stubborn facts."

"Erysipelas in Childbed without Puerperal Fever" is the title of Dr. Henry F. Campbell's paper, and, while based upon an isolated experience on his part, we fancy it can be duplicated by many a general practitioner: its discussion puts on record the opinion of the members of the Society in an exceedingly valuable way.

"Expansion of the Bladder over the Surface of Abdominal Tumors, and its Attachment to Them or to the Abdominal Walls as a Complication of Laparotomy," by T. Gailard Thomas, M.D., will excite especial interest with the operator, rather than with the general professional reader.

"Fibroid Polypus, with Partial Inversion of the Uterus, with Specimen," by Thaddeus A. Reamy, M.D., is a useful paper for the embryo operators in this specialty, or—pardon us—in this main branch of medical science, which includes the trunk and all the foliage and roots.

Dr. Albert H. Smith, of Philadelphia, read a paper on "Axis Traction with the Obstetric Forceps." The ideas advanced by Dr. Smith are generally familiar to the profession in Philadelphia, having been taught by him for many years.

The remaining papers are on "Measurements of the Uterine Cavity in Childbed," by Dr. A. D. Sinclair; "Jaundice in Pregnancy," by Dr. J. W. Underhill; and "The Practice of Gynecology in Ancient Times," by Dr. Ed. W. Jenks. This paper makes us almost certain that it was, as has been suspected, a good thing for the world when the lamented Alexandrian Library was destroyed. There were too many books, and there was too little in them. There will be need of a similar accident again before long, to clear the medico-literary atmosphere and free men's minds from over-weighting. The dark ages are bewailed as so much time lost, while they were really only the reaction after reading the innumerable Alexandrian volumes, the lethargic sleep of a world mentally gorged with indigestible ideas, from which humanity arose refreshed and entered with vigor on the race of modern times. Aetius, who spent his life in study at Alexandria, who used the library and undoubtedly extracted all he could from it one hundred and fifty years before its destruction,

and whose works are extant, seems to have made a very moderate "find." The ancients, however, had uterine specula, Dr. Jenks informs us, and sponge tents, but, alas! they had no carbolic spray, and, in short, Dr. Jenks's paper only goes to prove that were all the lost wisdom of antiquity restored to us it would be found to-day of no value whatever.

The volume concludes with six papers by candidates elected to fellowship, and valuable indices of gynecologic and obstetric literature.

E. W. W.

## GLEANINGS FROM EXCHANGES.

ARSENICAL POISONING—UNUSUAL POST-MORTEM APPEARANCES.—Dr. A. R. Davidson reports the following in the *Buffalo Medical and Surgical Journal* (October, 1882):

"Where the arsenic has been taken with food, it occasionally happens that death may occur from its effects, and neither the stomach nor intestines present an abnormal appearance. Evidence of poisoning upon post-mortem examination would be here entirely wanting. Such cases are undoubtedly very rare; but the possibility of their occurrence is not to be overlooked, as they teach the important fact in legal medicine that the non-existence of striking changes in the alimentary canal after death is no proof that the party has not died from the effects of an irritant poison. It is for this reason that I report the following case:

"August 24, 1882, several biscuits were placed in my hands by one of the coroners of Erie County for analysis. Upon examination they were found to contain a quantity of arsenic equal to about sixteen grains in each biscuit. A portion of a family—mother and three children—had partaken of the biscuit quite freely at their evening meal, and had all been violently sick with the well-known and characteristic symptoms due to the poison. After twelve hours, one of the children, a boy of six years, died. Eight days after, the body was exhumed in my presence; the stomach, kidneys, and liver removed; the rectum was opened, and found to be free from all indications of inflammation.

"The stomach contained a very little whitish fluid, and, upon inspection, the mucous membrane was found to be paler than normal, and absolutely free from any semblance of inflammatory action. An analysis proved it to contain a mere trace of arsenic.

"The liver and kidneys, treated by Fresenius and Von Babo's method, yielded a little more than half a grain of arsenious acid.

"The explanation of these exceptional cases, and of the common ones of recovery after large quantities of poison have been taken with food, is doubtless that the food so



envelops the poison that it is prevented from attaching itself to the mucous membrane; and when emesis occurs, the arsenic may be entirely thrown off with the contents of the stomach. The amount absorbed before its emetic action is evoked is frequently insufficient to produce death. While a part of the poison is rapidly eliminated by the kidneys, another part seems to be temporarily deposited in the liver, and thereby withdrawn from the circulation. From the observations of the late Dr. Geohagan, it appears that the deposit of arsenic in the liver rapidly increases up to about fifteen hours after the poison has been taken, when that organ may contain as much as two grains of arsenic. If the person survives, it then very gradually diminishes in quantity, and entirely disappears in from fourteen to seventeen days."

**POISONING BY DAPHNE MEZEREON.**—Dr. Shaw reports the following in the *British Medical Journal*: "On July 14 last, a little girl aged two and one-half years was brought to me by her father, who said that about half an hour previously she had eaten some red berries from a shrub in front of the house which he believed to be poisonous, and he thereupon produced some berries and leaves of the ordinary cultivated mezereon. The child had been sick on the road, but had not vomited much. No one knew how many berries she might have swallowed, for she had been alone for ten minutes, and her hands were full when discovered. There was nothing remarkable in her appearance, except that she seemed somewhat dull and stupid. I gave her an emetic of five grains of sulphate of zinc in a little warm water, which made her very sick, but brought nothing up but a clear liquid. I then gave her some ipecacuanha wine, and sent her home, with instructions for her to have a dose of castor oil after the emetic had acted. She was again sick, with the same result as before, and they had barely reached home (a ten minutes' walk) when she suddenly became pale, and began to cry and shiver violently, and very soon became unconscious. I was hastily summoned by a messenger, saying that she was dying, and on my arrival I found her lying quite still and motionless, her eyes wide open, pupils fixed and dilated, face blue, scarcely any pulse perceptible, and breathing very faint and slow. I had her wrapped in a warm blanket, gave her some ammonia and brandy, and ordered a mustard poultice to be put on her chest. She could only be roused with great difficulty, and her skin seemed quite insensible to touch. She revived a little after the stimulant, and moved her legs and arms about; the pulse also became quite distinct at the wrist. The mother noticed now, for the first time, that the lips looked as though they had been burnt, and that the inside of the mouth was swollen.

She remained in this condition for an hour, when she began to look about and put her hands to her chest, where the mustard had been. The pupils still remained quite indifferent to light. Two hours later the bowels acted violently, and a copious motion was passed, containing half-digested food, something like curdled milk, and a number of small hard seeds, some of which were partly enveloped in pulp. After carefully straining a portion, I found twenty-four of these, and I believe there were fully as many more in the remainder. The child still continued drowsy, though otherwise better. I now gave a dose of castor oil, and left. There was afterwards another evacuation, and a few more seeds were seen. She continued to improve, sleeping heavily all the following morning, and in the evening had apparently forgotten all about it.

"The quick passage of the poison through the stomach into the intestines was, I think, unquestionably the secret of recovery in this patient. I am not aware of any case having been recorded where so large a number of berries had been taken without a fatal result. Most writers seem to agree that very few are sufficient to cause death. Guy and Ferrier say from six to eight, and Orfila mentions a case, on the authority of Linnæus, where a young lady suffering from intermittent fever had died, 'spitting blood, after twelve berries had been given for the purpose of purging her' ('On Poisons,' vol. ii. p. 27, second edition). The narcotic symptoms, which were so marked a feature, are disputed by some authorities, who place daphne with the simple vegetable irritants, although Christison, in his work on 'Poisons' (fourth edition, page 601), quotes one instance where, amongst several children who died with symptoms of violent vomiting and purging, one was distinctly narcotized."

**THE USE OF BELLADONNA IN SYNCOPE AND CARDIAC FAILURE.**—In a communication on "Some Medical and Surgical Uses of Belladonna or its Alkaloid," Dr. J. H. Whelan calls attention to the physiological fact that belladonna has the power of doing away with the inhibitory action of the vagus on the heart, and insists that syncopical attacks are in the main caused by reflex cardio-inhibition. In surgery, atropia given prior to chloroform anæsthesia is, therefore, of great service in preventing heart-failure; also in shock, threatened collapse, etc.

"In medicine there are many cases in which belladonna or its alkaloid would prove useful. In some extreme cases of hysteria or allied disorders we have patients going from one faint into another, frequent syncopical attacks. In the allied abnormal condition of pregnancy—that called by old authors hypothermia—we have the same condition. In both this drug ought to prove extremely use-

ful. In the former we have impulses originating probably in the higher centres, causing frequent inhibitions; in the latter, the less noble organ, the uterus, takes the place of the brain. In certain apparently asthenic inflammations, particularly in peritonitis, a very weak pulse is a common thing. One would imagine that this, which is fast, could in no way be connected with the so-called cardio-inhibitory mechanism; but it is just possible that it might. The inhibitory fibres, being acted on slowly and gradually, become in part exhausted, while the 'accelerator' nerves might develop into action."

He also states that "belladonna is sometimes serviceable in annoying nocturnal emissions. It will be found very useful, indeed, if the emissions be accompanied with erections, but perfectly useless if they be not so accompanied. This is in keeping with Nicolski's results, that atropine paralyzes the 'dilator' fibres of the nervi erigentes, while muscarine produces erection apparently by stimulating the local dilator mechanism, thus resembling what appertains to the heart. When, therefore, we have a case of excessive nocturnal emissions with erections, minute doses of belladonna and bromide of potassium will speedily effect a cure when exhibited at bedtime.

"Dr. Gentilhomme, of Reims, I see by the late journals, has employed a pill containing one-hundredth of a grain of sulphate of atropine in a patient suffering from coryza, and very subject to it, with very excellent results. Fifteen minutes after the first administration all sneezing had ceased, the secretion stopped, and respiration became normal. Eventually the attacks diminished, and finally disappeared under its influence. If Gentilhomme's conclusions turn out correct, there will be a very decided improvement made in the treatment of catarrh. Dr. G. Johnson's treatment by full doses of opium invariably gives rise to unpleasant sequential symptoms, while Jupes Styrup's frequent minute doses with antimony are very depressing, to which I can bear personal testimony."—*Lancet*.

**REVIVAL OF BLOOD-LETTING AS A THERAPEUTIC RESOURCE.**—In the Paris letter to the *Lancet*, the views of two of the most prominent practitioners of that city with regard to blood-letting are referred to as follows: "Professor Peter, who was one of Trousseau's most fervent disciples, and present editor of his clinical work, employs venesection on rather a large scale, particularly in cases of apoplexy and epilepsy, in which Professor Trousseau condemned it altogether. At his clinical meetings, and in his lectures at the School of Medicine, Prof. Peter teaches that, with all deference to his former master, he has found by experience that blood-letting, if judiciously employed, is invaluable in some cases, and apoplexy is just one of those in which it would be found useful.

As in the days before the publication of Professor Trousseau's clinical works, Professor Peter practises blood letting at the moment of the attack, with the hope of cutting it short, and he does so at a later stage with the view of facilitating the reabsorption of the clot of blood formed at the seat of the lesion, and to moderate the congestion in its neighborhood. On the strength of this theory, Professor Peter, at his clinic, lately bled a patient who was upwards of sixty for an attack of apoplexy and hemiplegia of the left side, and he declared, at a meeting of the Medical Society, that this bleeding had been the means of saving the patient from imminent death. He employs general depletion even in the convulsions following apoplexy, with great benefit to the patient, as he had noticed that, notwithstanding the presence of a large quantity of albumen in the urine, the convulsions and the albumen had entirely disappeared after a small bleeding from the arm. Professor Vulpian employs blood-letting in its various forms in all cases of inflammation, and he has found it invaluable in peritonitis, whether from puerperal or other causes. At the Clinique d'Accouchement, Professor Depaul scarcely employs anything else in puerperal convulsions. He bleeds the patients largely and repeatedly until the most urgent symptoms are relieved, and he has frequently stated at the Academy of Medicine and at other medical societies that the results of the practice that he has carried out for more than a quarter of a century can bear comparison with any other method of treatment adopted by other physicians in similar cases: in fact, the mortality among his patients has always been considerably less."

**ON A PECULIAR REDUCING SUBSTANCE IN THE URINE FROM THE INTERNAL EMPLOYMENT OF TURPENTINE.**—From the researches of M. Vetlesen, in the Physiological Institute of Christiania, published in the *Nordiskt Medicinskt Arkiv* for 1882, it appears that during the internal employment of turpentine the urine contains a rather large quantity of a reducing substance, which in its reactions (such as blackening, on boiling, an alkaline solution of oxide of bismuth, and reducing the peroxide of copper to the suboxide) seems to be composed in great part of a matter strongly resembling grape-sugar, without, however, being in any way identical with it. The author, in fact, has never succeeded with the polarizing apparatus in observing the rotation to the right side. The reaction disappears after fermentation, which process appears to act more slowly. Experiments subsequently showed that a small quantity of hydrochloric acid destroyed this reducing substance even at a relatively low temperature, while under the same circumstances it was proved that grape-sugar is only slightly destroyed. The reducing substance described

by M. Vetlesen is, in all probability, optically indifferent; it disappears by fermentation with rather more difficulty than grape-sugar; but, as it does so when the urine is simply left to rest for about five days, it might perhaps be supposed that it is not a fermentable body. But M. Otto has traced in one experiment, and after fermentation, some alcohol in the distilled product, while before fermentation the urine gave only a negative result. It may be admitted as the result of the experiment that the substance appearing in the urine during the internal use of turpentine is a kind of fermentable sugar, the nature of which, however, is not yet specially determined. The researches made appear to show that the quantity of this reducing substance is in relation to the amount of the dose of turpentine, and that it diminishes if the use of this drug be continued for a certain time.—*Medical Times and Gazette.*

**CEREBRAL TUMOR—AUTOPSY—ENDOTHELIOMA.**—Under the care of Dr. Philipson.—J. M., aged 36, machinist, was admitted into the Newcastle-on-Tyne Infirmary, May 11, 1882, in a state of stupor, and complaining of pain at front and back of head. Patient could give very little account of himself. His friends stated that he had first complained of pain in the head four months previously, and that for the last three months he had been unable to work; also, that he had attacks of vomiting and giddiness from time to time. No history nor any signs of syphilis; nor at this time could any history of cranial injury be got, but after his death his friends admitted that he had had some injury to the head.

When admitted, patient was in a state of stupor. Memory appeared much affected. There was double internal strabismus, with unequal pupils; double optic neuritis. Hearing unaffected; sense of smell lost. Lies on back; stumbles on trying to walk. Is with difficulty got to answer questions; speech slow and hesitating; pain in head apparently increased by percussion in right frontal region.

From the sickness, headache, double optic neuritis, etc., Dr. Philipson diagnosed the presence of a cerebral tumor, probably situated in the frontal region.

May 20.—Patient still more torpid, bowels obstinately confined, can scarcely be got to take any food, pupils insensible to light. He died seven days later.

Post-mortem examination.—When the calvaria was removed, the membranes appeared normal. The right frontal bone had on its internal surface a much greater concavity than the left, and at its upper and outer part was rough, deeper in color, and thinned. The dura mater was very adherent towards the front of the longitudinal fissure, and over the right frontal lobe. The right frontal lobe was very hard to the touch, and was gray and mottled, and in all its diameters

it was larger than was the left lobe. On section a new growth was discovered, which presented an almost fibrous resistance to the knife, and was found to occupy the whole of the right frontal lobe. It was grayish, with a ragged outline, and measured three inches in each diameter. It was surrounded by soft diffuent cerebral tissue; but all the rest of the brain was healthy. On microscopical examination the tumor was found to present all the characters of an endothelioma.—*Medical Times and Gazette.*

**MODE OF VACCINATING.**—Dr. Chas. F. Moore, in a short paper read before the British Medical Association, adopts the following method:

"With a perfectly clean sharp lancet, I make five or six single scarifications, holding the lancet as a pen is held, resting securely but gently on the arm of the person operated on, which I hold with the left hand. The operation, thus performed, scarcely occupies two seconds, and when done lightly, but sufficiently, does not waken a sleeping infant, nor cause a waking child to cry, provided the attention be diverted by gently stroking the arm, or otherwise engaging the attention. The lymph from the arm of another child, or preserved in tubes or on points, is then to be gently rubbed with the flat of the lancet or charged points across the little wounds, which may be made to gape by slight traction on the adjacent skin. It is neither necessary nor desirable to make the incisions at all deep; and, if the appearance of a little blood do not speedily occur, getting the parent to gently 'hoist' the child, which does not waken a sleeping infant, will generally give the circulation sufficient impetus to cause a slight but sufficient evidence that the cutis was reached by the incisions.

"The result of this mode of operating I have found to be one or more, usually two, separate vesicles, or an oblong compound one at the site of each pair of scratches, and one at the site of the single scratch, or more if six were made in all, or if they were made longer than usual."—*British Medical Journal.*

**BLUE MARKS AND PEDICULI.**—Some years ago the fact that blue spots or dusky spots are often observed in association with pediculi pubis was pointed out by M. Mourson, a French naval surgeon. Subsequently M. Duguët furnished a demonstration of the relation between the two by producing blue spots by means of inserting beneath the epidermis a small quantity of a sort of paste made of bruised pediculi. Hence it is clear that the pediculi pubis contain some substance having coloring properties. Further observations by M. Mallet, a pupil of Duguët, make it probable that this substance is contained in the salivary glands. By means of fine forceps

the head of a pediculus was torn off and inserted beneath the epidermis of the forearm, and near it the rest of the louse was similarly interred. Next day a blue mark was distinct around the body of the insect, but not around the head. In another experiment a small mass came away from the body of the insect with the head, and in this case the dusky spot developed around the head and not around the body. Further experiments showed that the coloring agent was situated in the body opposite the anterior pair of legs, and at this level it is known that there are two pairs of salivary glands. M. Duguet has pointed out some curious facts regarding the resistance of some persons to the action of the salivary juice and the influence of season on the coloring power of the insect. The blue spots are far more abundant in February, March, and April than in other months.—*Lancet*.

**SILVESTER'S METHOD IN DROWNING AT PARIS.**—Dr. A. Voisin communicated to the Rochelle Congress (*Gaz. des Hôp.*, September 5), the satisfactory results which have attended the great efforts made for some years past by the Paris Municipality to improve the treatment of drowned persons in that capital,—efforts which Dr. Voisin has been the chief instrument in carrying out. He now reports the results which have been obtained: 1. The almost absolute certainty of restoring life to persons who have remained under water, or "between two waters," for a period varying from a few seconds to five minutes, no one formerly having been saved after three minutes' submersion. 2. He has succeeded in restoring to life persons who have remained under water from five to twenty minutes. 3. These results have been obtained in individuals not merely in a state of syncope, but in an asphyxiated state, as shown by their violaceous face and lips, their open mouth, and flaccid masseters. 4. These results have been gained in consequence of the excellent arrangements made for the rigorous carrying out of Silvester's method; the effectual application of warmth to the whole surface of the body by calorific generators; the ready access to warm baths and cold douches; the keeping the patient quietly in bed for some hours after his restoration; the whole system being administered by a well-trained and disciplined staff, which is kept in constant readiness.—*Medical Times and Gazette*.

**ON THE TREATMENT OF CONTRACTED FINGERS.**—A powerful man some months ago scratched his little finger with a meat-bone. The usual train of symptoms followed, and when I saw him the tip of the little finger was so tightly approximated to the palm that no force could separate it, and strong fibrous bands corresponding with the primary flexures were readily observed; and, as I thought the tendon

was uninvolved and still ran in a tolerably free theca, I divided the bands with a Von Graefe's iridectomy-knife, which is singularly useful for fine plastic work, and extended the fingers forcibly. No good came of this proceeding. I subsequently placed him under an anæsthetic, and carefully and thoroughly extirpated the entire cicatricial tissues, and divided the tendon, with antiseptic precautions. The finger was carefully retained in the straight position, a metal circlet was made for the wrist, and a piece of stout steel clock-spring welded on to it. This steel spring was carried up the dorsum of the finger and suitably attached to it. By its tension it effectually kept the parts on the stretch, and, when the wound had healed, passive and active movements, conducted by the patient himself, brought about an excellent result. The finger is as straight as the others, and will be, no doubt, ultimately quite as useful.—EDWARD BELLAMY, in *The Lancet*.

**PROF. VERNEUIL ON TRANSFUSION.**—During a discussion on this subject at the meeting of the Association Française, at Rochelle (*Gaz. Hebdomadaire*, September 2), Prof. Verneuil expressed his opinion that transfusion is often a very difficult and dangerous operation, and almost always a useless one. In place of occupying ourselves with the mechanical procedures of the operation, it would be better to consider its physiological pathology, its indications, and its contra-indications. It is not always followed by death, and in some cases it seems even to have saved the patient; but fortunate results are only observed when a very small quantity of blood has been injected. It is not by its globules, by the elements of nutrition which it furnishes to the tissues, that injected blood acts, but by a general dynamic reaction which it induces by its contact with the endothelium of the vascular system. Ether injected into the cellular tissue produces the same reaction, arousing the exhausted organic forces. In presence of the difficulty of the operation, and the defects of the apparatus in use, Prof. Verneuil prefers the ether injections, all the more as he does not believe that there exists a case on record proving that transfusion has succeeded where all other means have failed.—*Medical Times and Gazette*.

**FATAL POISONING BY ERGOT.**—A hospital nurse, 28 years of age, five months pregnant, took a quantity of powdered ergot ("two handfuls"), to produce abortion. She had for several months previously taken the fluid extract, but without effect. The symptoms produced by the powder, taken dry and not infused, were vomiting of reddish-brown, pul-taceous matter; the lips, and the base and middle of the tongue, were swollen and covered with dry black blood; the lips and edges of the tongue were darker-colored than normal,



but moist. The skin was pale and cool, temperature in the axilla  $96^{\circ}$ , when seen about ten hours after taking the drug. The upper portion of the body was intensely jaundiced. Ecchymoses were seen under the eyes. Patient was in an apathetic condition, with stupor occasionally. She lay chiefly upon the right side. The pulse was peculiar: it was rapid, soft, and disappeared under slight pressure, so that it could not be counted. Respiration noisy and labored, forty-eight to the minute. The area and force of the cardiac pulsation were both increased, while the impulse against the chest-walls was rolling in character: it beat one hundred and fifty to the minute. There was congestion at base of right lung. The patient died from progressive asystole. At the autopsy numerous capillary hemorrhages were found in the various tissues and viscera, although none occurred in the brain. The stomach and abdominal cavity contained exuded blood; the lungs were anæmic, with the exception of minute hemorrhages and the right basic congestion; the heart was empty; the uterus contained a fetus, but neither liquor amnii nor blood.—*Lancet*.

**SYPHILITIC POLYURIA.**—There is, according to Professor Semmola, of Naples, a form of cerebral syphilis which may be the cause of polyuria.

The *Revista de Ciencias Médicas* of Barcelona speaks of three cases already reported by the doctor in favor of his opinion. In one of those cases (the most characteristic of all) the patient used to void forty-three pints of urine in twenty-four hours, with a specific gravity varying between 1001 and 1005. He had seen several physicians, but, feeling no relief from their treatment, he finally consulted Professor Semmola, who found out that the man was affected with a chronic syphilis, to which he attributed the cause of his disease; very probably some syphilitic lymph or deposit was locally effused into the walls of the fourth ventricle of the brain, and so had pathologically reproduced the celebrated physiological experiment of Claude Bernard,—that is, to produce polyuria and sugar in the urine of dogs by simply puncturing with a needle the floor of the fourth ventricle. Based upon this diagnosis, the patient was submitted to a general antisyphilitic treatment, which consisted in hypodermic injections of albuminate of mercury and the long-continued use of iodide of potassium. In two months he was perfectly cured.—*New Orleans Medical and Surgical Journal*.

**VACCINAL MICROCOCCI.**—M. Strauss presented to a recent meeting of the Société de Biologie a series of microscopical preparations of the vaccinal pustule from the calf, at different stages of its progress, in which the presence of the special micrococcus could readily be observed. The method of prepara-

tion adopted was to place the excised fragments of skin in absolute alcohol, to cut sections and stain them by the method of Weigert, which consists in tinting with methylamine violet, and then discoloring them until only the nuclei, the bacteria, and the micrococci remained visible. Under a strong magnifying power the latter were visible as extremely minute points, tinted blue, about a thousandth part of a millimetre in diameter, and grouped in colonies. They were seen in the borders of the inoculation wound, and in the Malpighian layer, and subsequently could be traced passing into the subjacent cutis, especially in the lymphatic spaces. The multiplication and extension of the organism seemed to coincide closely with the development of the pustule.—*Lancet*.

**CYSTICERCUS, OR PORK-MEASLE, IN MAN.**—M. Troisier exhibited lately to the members of the Paris Hospital Medical Society a man 36 years old, a Parisian, who for a year past had noticed small swellings arise on the cheek, arms, legs, and abdominal walls. These swellings proved to be due to cysticerci, and, curiously enough, the patient had passed a tænia solium whilst bearing these larvæ in his body. M. Troisier suggested two hypothetical explanations of the coincidence,—either that the man had swallowed the ova of his own tape-worm, or that tape-worm and cysticerci were derived from the same external source. He asked what treatment should be followed to rid the patient of his disease. No one could dream of removing them one by one, but some such simple method as puncture with the hypodermic syringe might suffice to kill them. Many similar cases are referred to by Lancereaux in his work on "Pathological Anatomy," although they are not so frequent as the occurrence of solitary cysticerci in organs. Lancereaux gives a figure showing numerous subcutaneous cysts in a woman, and among other facts quotes the statement of Rudolphin to the effect that in his time, at Berlin, cysticerci were found in one out of every fifty post-mortem examinations, occurring most often in the gluteal, psoas, iliacus, and vasti muscles, and more rarely in the brain. Bonhomme, in one case, calculated that there were as many as two thousand lodged in the subcutaneous, subfacial, and intermuscular connective tissue.—*Lancet*.

**CONTAGIOUSNESS OF PHTHISIS.**—Dr. Vincent Edwards, for seventeen years resident medical officer at Brompton Hospital for Consumptives, gives the following facts telling against the asserted contagiousness of consumption. Of fifty-nine resident medical assistants who lived in the hospital an average of six months each, only two are dead, and these not from phthisis. Three of the living are said to have phthisis. The chaplain and the matron had each lived there for over sixteen years. Very many nurses had been in

residence for periods varying from months to several years. The head nurses, says the writer, sleep each in a room containing fifty patients. Two head nurses only are known to have died; one from apoplexy; the other head nurse was here seven months, was unhappily married, and some time afterwards died of phthisis. Of the nurses now in residence, one has been here twenty-four years, two twelve years, one eight years, one seven years, one six and a half years, and one five years. No under-nurse, as far as I am aware, has died of phthisis. All the physicians who have attended the in- and out-patients during the past seventeen years are living, except two, who did not die from phthisis.—*Medical Record*.

**REDUPLICATION OF THE HEART-SOUNDS.**—Dr. D'Espine has examined with the cardiograph a number of clinical patients in whom the heart-sounds were modified in various ways. He finds that reduplication of the first sound depends on the contraction of the ventricular region in two separate segments, but never on successive contraction of the two ventricles. Increased tension in the aorta seems to be an essential condition of the phenomenon of reduplication, but it is not by itself sufficient to produce the phenomenon. On the other hand, reduplication of the second sound is determined by the failure of the aortic and pulmonary sigmoid valves to close simultaneously. Double diastolic impulse occurs in two diseases: (1.) In aortic insufficiency with great regurgitation; it is then a bad symptom. (2.) In mitral insufficiency with stenosis and hypertrophy of the left auricle; it then depends on a secondary wave starting from the auricle, and is really a kind of premature præ systolic effect.—*Revue de Médecine; Practitioner*.

### MISCELLANY.

**ECONOMICAL SOAP.**—The properties of soap and of silicate of soda possess great analogy. The combinations of weak acids possess a slightly alkaline reaction, their solutions being capable of forming an emulsion with fatty substances. These properties in common have led to the manufacture of cheap soaps, containing a large proportion of silicate of soda or soluble glass. Two processes may be employed: (1) the addition of a concentrated solution of silicate of soda to fatty or resinous soap, and (2) the saponification of fatty or resinous substances by alkaloids in the presence of silicate of soda. By either method a soap is obtained, suitable for all the uses to which ordinary soap has hitherto been applied, and at a much lower price, as silicate of soda is extremely cheap.—*Boston Journal of Chemistry*.

**BACILLUS GYNOPHILIA.**—The origin of this dread disease, commonly known under the

title of "love of the opposite sex," has recently been discovered by a California physician (*Washington Post*) to be a bacillus. This has been cultivated, and certain persons inoculated with it, with the following results. The inoculation was invariably successful, symptoms of the disease appearing in a very short time after the operation. A bachelor, an inveterate woman-hater, aged fifty, the first day after inoculation had his whiskers dyed, ordered a new suit of clothes and a set of false teeth, bought a top-buggy, a bottle of hair restorer, a diamond ring, and a guitar, and began reading Byron's poems. The inoculation produced symptoms of the same nature in a young lady of forty-five. She spent five dollars at a drug-store for cosmetics, bought a lot of new hair and a croquet set, sang "Empty is the Cradle," sent out invitations for a party, and complained that the young men did not go into society.—*American Medical Weekly*.

**GLYCERIN AND GLUE.**—A German chemist named Puscher, a native of Nuremberg, reported to the trades-union of that place that he met with great success in using glycerin together with glue. While generally, after the drying of the glue, the thing to which it is applied is liable to break, tear, or spring off, if a quantity of glycerin equal to a quarter of the quantity of glue be mixed together, that defect will entirely disappear. Puscher also made use of this glue for lining leather, for making globe-frames, and for smoothing parchment and chalk paper. He also used it for polishing, mixing wax with the glycerin, and using it as an underground for laying on aniline red color. The red was found to exceed all others in which glycerin is not used. The glycerin has also some properties in common with india-rubber, for it will blot out pencil-marks from paper, so as to leave no mark whatever. A paste made of starch, glycerin, and gypsum will maintain its plasticity and adhesiveness longer than any other cement, and therefore recommends itself for cementing chemical instruments and apparatus used by pharmacists.—*Boston Journal of Chemistry*.

**DEATH IN THE DYEING.**—According to a Vienna journal, a death has occurred in Warsaw in consequence of wearing cinnamon-colored underclothing. The dye faded under perspiration, and was partially absorbed by the skin, and poisonous matter contained in it caused death. The first symptoms were vertigo, bleeding from the mouth, and loss of sight. Physicians were unable to give relief, and the victim died in agony. He gave the name of the trader from whom he bought the underclothing in Vienna, and the Warsaw and Viennese police have been in communication about the occurrence. A solution of the dye given internally to a dog produced death in an hour.—*Sanitary Engineer*.

**MILK AS A VEHICLE FOR FEVER.**—An outbreak of fever in the outskirts of Glasgow has been traced by the officers of health to a poisoned milk-supply. (*British Medical Journal* for September 23.) "It appears that this farm when visited was found to be in a very unsanitary condition, and in the farmhouse itself one of the inmates had recently been suffering illness of a febrile character." By the way, what is the condition, hygienic or otherwise, of the sources from which our city milk comes? Has any one tried to find out?

**GLACIALINE.**—According to Dr. Besana, this substance, which has met with so much favor in England and elsewhere as an antiseptic, especially for the preservation of milk, meat, and other articles of food, has the following composition: boracic acid, 18 parts; borax, 9 parts; sugar, 9 parts; glycerin, 6 parts. A Roman composition of a similar kind was found to be nothing but pure boracic acid. It is called salt of glacialine, and sells at five francs per kilogram (about forty-five cents a pound), the market price of boracic acid being exactly half that rate.—*Boston Journal of Chemistry*.

THE majority of the cheap cigarettes contain more nicotine in proportion to the tobacco in them than does an ordinary cigar; one reason for this being that many of them are made from cigar-stumps which are carefully collected for this purpose, and these cigar-stumps are saturated with nicotine distilled into them by the slow combustion of the cigar.

A CASE involving some medico-legal points was recently tried in Chicago. A girl died from metro-peritonitis. A midwife was tried for causing her death by attempt to produce abortion. The necropsy showed that there had been apparently an attempt to produce abortion, but that the girl had never been pregnant.

THERE is eminent medical authority for the statement that unripe or very old potatoes contain a certain quantity of solanine. This may produce serious results, if the potatoes are boiled with their skins on, and if they are eaten in large quantities.—*Boston Journal of Chemistry*.

A DIFFERENCE WITH A DISTINCTION.—Alphonse Karr, talking of food adulteration, remarked, "It's very curious, isn't it? If I poison my grocer, the very lightest sentence will be hard labor for life; but if my grocer poisons me—ah, that's a different thing!—he is fined forty francs!"

**CACODYLE.**—At the Société de Biologie, Paris, Rabuteau announced that he had demonstrated properties analogous to curare, and that, in doses considerably elevated, the substance resembled the arsenical compounds in its physiological properties.—*Le Progrès Médical*.

**FEMALE MEDICAL STUDENTS IN RUSSIA.**—It is officially announced that, by order of the emperor, the admission of new pupils to the course of medical training for women at the Nicolai Military Hospital, in St. Petersburg, will be discontinued after the present term. The students will, however, be allowed to conclude their course, after which the clinical instruction for women at the hospital will be abolished. The educational appliances, library, etc., are to be handed over either to the Military Academy of Medicine or to any establishment that may be prepared to open courses of medical instruction for women.

**EX UNO DISCE OMNES.**—The *Chicago Medical Review* is responsible for the following: A Cyprian in Chicago fell into labor and was delivered by an accoucheur noted for his punctilious observance of all the requirements of the laws. In making out the return of the birth he was obliged to perform an impossibility, *i.e.*, to state the name of the father of the child. When he came to this a bright thought struck him, so he escaped the quandary and satisfied his conscience and his patriotism by writing "E Pluribus Unum." For his services he should, and doubtless did, receive nothing less than an American eagle.

THE French minister of agriculture has placed the sum of 50,000 francs at the disposal of M. Pasteur for his scientific researches into the contagious diseases of animals. The illustrious *savant* had already received grants of 50,000 francs in 1880 and 40,000 francs in 1881.

**PEDICULI CAPITIS.**—A solution of hydrarg. chlorid. corrosiv. in dilute acetic acid (gr. ij to ℥j) destroys both pediculi and nits in one application. The use of warm water and soap subsequently obviates any danger from absorption of the mercury.

MR. J. T. CLOVER, the Lecturer on Anæsthetics at the University College Hospital, London, is dead.

**A PARASITIC AFFECTION IN DIABETIC PATIENTS.**—At the International Medical Congress, the late Prof. Simon called attention to an inflammation of the prepuce in diabetic patients due to the growth of (mycelium) fungus in the mixture of sebum and diabetic urine retained in the preputial fold. In some cases this is the only symptom that the patient complains of. Possibly pruritus of the vulva in women may find in some cases a like explanation.

**DEATH FROM PERFORATION OF THE ŒSOPHAGUS AND THORACIC AORTA.**—In the *Wiener Med. Wochenschrift*, No. 35, Dr. Ludwig Klaar reports a fatal case of perforation of the Œsophagus, due to a wood-shaving having become impacted in the gullet at the level of the bifurcation of the trachea. The thoracic aorta was eaten into, and this led to the man's death by profuse hemorrhage.

FATE seems to come a long way to meet some victims. Mr. S. R. Aitken, of Colombo, Ceylon, was recently killed by a prescription for tape-worm taken from the seventh edition of "Medical Therapeutics," by George A. Napheys, M.D., edited by Dr. D. G. Brinton. The number of deaths indirectly produced by the half-culture and routine practice encouraged by such books finds no record.

THE St. Joseph Hospital Medical College and the College of Physicians and Surgeons of St. Joseph have united under the charter of the former, with the name of the St. Joseph Medical College.

THE Jewish doctors of the Russian army are being made the especial targets of official persecution.

OXYGENATED WATER is used in some of the Paris hospitals as an antiseptic surgical dressing.

## NOTES AND QUERIES.

TO THE EDITOR OF THE PHILADELPHIA MEDICAL TIMES:

DEAR SIR,—The daily papers have informed the public that a member of the obstetric staff of Blockley has been removed for "performing an operation of a private nature before the class." I have understood that this was nothing more nor less than bringing an obstetric case into the amphitheatre. Now, while at the first glance it might seem to a layman a harsh and immodest proceeding, it would cease to seem so when he considered for a moment why it was done. While generally the more difficult surgical operations, no matter how suddenly demanded, fall into old and experienced hands, the most serious emergencies of childbirth may be thrust at any time upon the graduate of a day. In the long summer months Philadelphia is almost depleted of its older physicians, and the public are often forced to take any one who exhibits a sign. In the country the recent graduate may be the only medical man in a circuit of many miles. Now, it is a blessing to the community when every graduate possesses that practical knowledge, even of normal cases, which only actual observation can give. We venture to assert that the experience of one case will do more to remove nervousness in the beginner, and therefore give him calmer judgment, and make him a vastly safer man for his patient, than scores of purely didactic lectures; and the man who brings a case before the class has conferred on its members and on the public a boon whose value is inestimable. This is the great necessity of our schools, and this has been the point on which foreign schools excelled us, for not many years ago the simplest operation in the affections peculiar to women, if demanding any exposure, was a sealed mystery to all the class except a favored few, who by peculiar advantages or special friendships were admitted as spectators or assistants. It is at present recognized as impossible to demand a practical knowledge of obstetrics as an indispensable requisite of a degree, for there is no way by which all the students could be admitted before graduation to obstetric wards, and, if there were, the objection made to the case recently exhibited at Blockley would be more forcible still against it, since it would require the exhibition of many more women.

We remember that the late Dr. John S. Parry looked upon every case of operation connected with the female sex which could be brought before the class as of the greatest importance, and that he prided himself more on having helped to break down the previously-existing barrier of false modesty which had prevailed at Blockley than on any other part of his invaluable work as a lecturer.

The only question, it seems to us, is as to the consent of the patient. If this be obtained, even after considerable persuasion, we think that over all other considerations the interests of education and the interests of the public in having educated physicians are paramount.

Yours sincerely,

E. W. WATSON.

201 NORTH TWENTIETH STREET, PHILADELPHIA.

### HALL OF PATHOLOGICAL SOCIETY, October 15, 1882.

DEAR SIR,—At a stated meeting held Thursday, October 12, 1882, the following officers were elected: President, James Tyson, M.D.; Vice-Presidents, J. Solis Cohen, F. P. Henry, E. O. Shakespeare, J. B. Roberts; Secretary, P. G. Skillern; Recorder, C. B. Nancrede; Treasurer, M. S. French; Curator, Carl Seiler.

Very respectfully yours,  
P. G. SKILLERN, Sec'y.

## OFFICIAL LIST

### OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY FROM OCTOBER 14 TO OCTOBER 28, 1882.

WILLIAMS, JOHN W., SURGEON.—To proceed to Vancouver Barracks, W.T., and report upon arrival to the Commanding General, Department of the Columbia, for assignment to duty in that department. S. O. 168, Military Division of the Pacific, October 13, 1882.

MOORE, JOHN, MAJOR AND SURGEON, MEDICAL DIRECTOR, HEADQUARTERS DEPARTMENT OF THE COLUMBIA.—Granted leave of absence for one month, with permission to apply to Headquarters, Military Division of the Pacific, for extension of one month. S. O. 145, Department of the Columbia, October 3, 1882.

TURRILL, HENRY S., CAPTAIN AND ASSISTANT-SURGEON.—Assigned to duty at Fort Omaha, Nebraska. S. O. 112, Paragraph 3, Department of the Platte, October 23, 1882.

LORING, LEONARD V., CAPTAIN AND ASSISTANT-SURGEON.—Granted leave of absence for four months. S. O. 243, A. G. O., October 18, 1882.

BYRNE, CHARLES B., CAPTAIN AND ASSISTANT-SURGEON.—Leave of absence extended ten days. S. O. 243, A. G. O., October 18, 1882.

BANISTER, JOHN M., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—The leave of absence granted by Paragraph 5, S. O. 203, Department of the Missouri, October 10, 1882, is extended one month. S. O. 113, Paragraph 2, Military Division of the Missouri, October 23, 1882.

OWEN, WM. O., JR., ASSISTANT-SURGEON.—Is relieved from duty at Fort Townsend, W.T., and assigned to duty at Vancouver Barracks, W.T. S. O. 148, Paragraph 1, Department of the Columbia, October 6, 1882.

BUSHNELL, GEORGE E., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Leave of absence extended one month. S. O. 244, A. G. O., October 19, 1882.

WILSON, GEORGE F., ASSISTANT-SURGEON.—Is relieved from duty at Vancouver Barracks, W.T., and assigned to duty at Fort Townsend, W.T. S. O. 148, Paragraph 1, Department of the Columbia, October 6, 1882.

BUSHNELL, GEORGE E., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Extension of one month's leave of absence is revoked. S. O. 247, Paragraph 2, A. G. O., October 23, 1882.

KANE, JOHN J., ASSISTANT-SURGEON.—Leave of absence granted October 9, 1882, Department of the Missouri, is extended two months. S. O. 247, Paragraph 3, A. G. O., October 23, 1882.

WYETH, M. C., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Will be relieved from duty at Fort Meade, D.T., upon his return from detached service, and will proceed to Fort Yates, D.T., and report to the commanding officer of that post for duty. S. O. 172, Department of Dakota, October 19, 1882.

APPEL, A. H., FIRST-LIEUTENANT AND ASSISTANT-SURGEON.—Granted leave of absence for one month. S. O. 168, Department of Dakota, October 14, 1882.

CARTER, EDWARD C., ASSISTANT-SURGEON.—Now at Camp Price, to proceed to Fort Thomas, and report to the commanding officer of that post for duty. S. O. 159, Department of Arizona, October 11, 1882.

EVERTS, EDWARD, ASSISTANT-SURGEON.—Assigned to duty at Fort Coeur d'Alene, I.T. S. O. 145, Department of the Columbia, October 3, 1882.

TAYLOR, A. W., ASSISTANT-SURGEON.—Relieved from duty at Fort Supply, I.T., and assigned to duty at Fort Cummings, New Mexico. S. O. 208, Department of the Missouri, October 16, 1882.